CITY OF BALTIMORE

HEALTH DEPT.

BUREAU OF

VITAL STATISTICS

DEATHS

BEGINNING 1910

CITY HALL
BALTIMORE 2, MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

RECORDS MANAGEMENT DIVISION

DECLARATION OF INTENT

THE CITY RECORDS MANAGEMENT OFFICER HEREBY DECLARES THAT THE RECORDS MICROFILMED HEREIN, ARE ACTUAL RECORDS OF THE DEPARTMENT OF Health BUREAU OF Vital Statistics CREATED D'RING THE NORMAL COURSE OF BUSINESS AND THAT THE MICROFILM WILL BE INSPECTED TO ASSURE COMPLETENESS OF COVERAGE, AND THAT:

THE MICROFILMING OF THE RECORDS IS ACCOMPLISHED AS PROVIDED FOR IN REQUEST FOR RETENTION PERIOD, AUTHORIZATION NO. 345 AS APPROVED BY THE RECORDS COMMITTEE IN ACCORDANCE WITH ORDINANCE NO. 1096 APPROVED BY THE MAYOR ON JUNE 4, 1954.

FORM RM-1 (11-58) RETAIN—PERM.

REQUEST FOR RETENTION PERIOD

To: Records Management Officer,
Room 408, City Hall, Baltimore, 2, Md.

Authorization No. 345

Department: Health

Bureau: Vital Statistics

Record Identification

1. TITLE:	2. Form No. if available	3. Type—(cards, paper, etc.)
Certificate of Death		Bound Book

4. Dates	5. Volume accumulated yearly	6. Size of Record	7. Number of copies made
		Misc.	One (1)

8. Authorization Requested (check only one (1) of the squares below)

A. [ ] Establish retention period for records which are accumulating daily.

B. [ ] Dispose of present accumulation, no additional accumulation anticipated.

C. [ ] Microfilm and destroy originals.

D. [X] Microfilm and retain originals for length of time indicated below.

9. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	10. Equipment and space freed.	11. In your opinion does this record have any historical significance?
12 yrs.	Micro. Perm.	12 yrs and Micro. Perm.		YES [ ] NO [X]

12. DESCRIPTION OF RECORD. (describe accurately and show recommended retention period.)

These are vital records known as Certificates of Death, required by statute to be registered with the Baltimore City Health Department within several days after the occurrence.

RETENTION PERIOD REQUESTED: Microfilm all Certificates in duplicate retaining the film permanently and store the duplicate rolls of film for security purposes.

Retain original death certificates Twelve (12) years after date of registration, and then destroy after microfilming.

Department or Bureau Approval: Robert E. Farber, M.D. Title: Commissioner of Health — 3/28/63 Date

Recommendation of Records Management Officer

13. Recommended Retention Period a. In Dept.	b. In Storage Center	c. Total	14. Disposal Method A	B	C
12 yrs.	Microfilm Permanent	12 yrs. and Microfilm Permanent	[ ] To be sold as scrap or waste paper	[X] To be Burned or shredded	[ ] Historical, (to be transferred to Dept. of Legislative Reference.)

REMARKS: 2 negative Rolls

C P Force — Records Management Officer — 3/28/63 Date

APPROVALS OF RECORDS DISPOSAL COMMITTEE

KINDLY RETURN TO: RECORDS MANAGEMENT OFFICER
ROOM 408, CITY HALL, BALTIMORE 2, MD.

1. APPROVED: CITY AUDITOR
2. APPROVED: CITY SOLICITOR
3. APPROVED: CITY COMPTROLLER
4. APPROVED: CITY TREASURER
5. APPROVED: DIRECTOR, DEPT. OF PUBLIC WORKS
6. APPROVED: DIRECTOR OF THE MUNICIPAL MUSEUM
7. APPROVED: DIRECTOR, DEPT. OF LEGISLATIVE REFERENCE

FILED ON FILM

IN

NUMERICAL ORDER

NOTICE

The succeeding documents were received in the same condition and microfilmed as shown.

Every effort was made to assure legibility and completeness.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44316

E 44316

CERTIFICATE OF DEATH

185

1-PLACE OF DEATH

City of Baltimore: (No.) 2103 Walbrook Ave. (Ward) 15-68

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie M. Bahr

(a) RESIDENCE NO. 2103 Walbrook Ave. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Harry L. Bahr

6 DATE OF BIRTH (month, day, and year): June 27-1865

7 AGE: Years 63 | Months 8 | Days 24 | IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town): Md.
(State or country)

PARENTS

10 NAME OF FATHER: Owen Edwards

11 BIRTHPLACE OF FATHER (city or town): Md.
(State or country)

12 MAIDEN NAME OF MOTHER: Sarah Schell

13 BIRTHPLACE OF MOTHER (city or town): Md
(State or country)

14 Informant: Harry L. Bahr
(Address): 2103 Walbrook Ave

15 Filed MAR 22 1929 Wm. H. Jones, M. D. Registrar

Dep

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 20th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to (his) death on the day stated above.
The CAUSE OF DEATH* was as follows:

Fractured Skull

(duration) ... yrs. ... mos. 4 ds.

CONTRIBUTORY (Secondary) Fall down Cellar Steps

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) Harbach, M. D.
Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery

DATE OF BURIAL: March 21 1929

20 UNDERTAKER: W. M. Routson

ADDRESS: 2235 N. Smith

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44317 ✓ E 44317

CERTIFICATE OF DEATH

164

1—PLACE OF DEATH

CITY OF BALTIMORE. (No.) 1331 (ST.) Herkimer (WARD) 25-72

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lucretia R. Buckingham

(a) RESIDENCE NO. 1331 (Usual place of abode) Herkimer ST., WARD (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed or divorced HUSBAND of (or) WIFE of Evan T. Buckingham

6 DATE OF BIRTH (month, day, and year) Jan. 3, 1835

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	94	2	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) A. A. Co. Md.

PARENTS

10 NAME OF FATHER Wm. Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mr. Wm. L. Downey

(Address) 1331 Herkimer St.

15 Filed MAR 22 1929, 19 C. H. WILLIAM JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 21 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb. 24, 1929, to March 21, 1929, that I last saw h... alive on ..., 19..., and that death occurred, on the date stated above, at 2.20 P m.

The CAUSE OF DEATH* was as follows:

General Debility

General and gradual weakness

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? General weakness

(Signed) Thos. H. Phillips, M. D.

, 19 (Address) 2300 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Melville Cem. Elkridge	Mar 23 1929
20 UNDERTAKER Wm J Rickner & Sons	ADDRESS North & Pa

Spec.—2-29-28—L. F. S.—500 Blks.

E 44318

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 44318

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3341 Avondale Ave ST. 7-55 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rufus B. Hudgins

(a) RESIDENCE NO. 3341 Avondale ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Bessie L

6 DATE OF BIRTH (month, day, and year): May-23 1882

7 AGE — Years: 46 Months: 9 Days: 28 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Machinist

(b) General nature of industry, business, or establishment in which employed (or employer): 031

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): North Carolina

10 NAME OF FATHER: Wm H. Hudgins

11 BIRTHPLACE OF FATHER (city or town) (State or country): South Carolina

12 MAIDEN NAME OF MOTHER: Mary H Reed

13 BIRTHPLACE OF MOTHER (city or town) (State or country): North Carolina

14 Informant: Bessie L. Hudgins

(Address): 3341 Avondale Ave

Filed MAR 22 1929 H. JONES M. D. Registrar

By: KW

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3-21-29

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1927, to March 21, 1929, that I last saw h[illegible] alive on March 21, 1929, and that death occurred, on the date stated above, at 8.45 P m.

The CAUSE OF DEATH* was as follows:

Uraemia

CONTRIBUTORY (Secondary): Nephritis (duration) yrs. mos. 3 ds.

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Charles L Reed, M. D.

, 19 (Address) 527 E Park Prof Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Winston Salem N C.

DATE OF BURIAL: 3/23 19[illegible]

20 UNDERTAKER: William Crooke

ADDRESS: 147 St Paul

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44319 — 24-021 — E 44319

CERTIFICATE OF DEATH

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS — REGISTERED NO.

CITY OF BALTIMORE: (No. 1074 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary L. Smith

(a) RESIDENCE NO. 812 Ensor St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert Smith

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland (State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Records of

(Address)

15 Filed 2 2 1929 C. Hampson Jones, M.D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 18, 1929

17 I HEREBY CERTIFY, That I attended deceased from January 4, 1928, to March 18, 1929, that I last saw her alive on March 18, 1929, and that death occurred, on the date stated above, at 2:15 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage, at

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Hypertension - arteriosclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) R. M. Hock, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	March 23, 29
20 UNDERTAKER	ADDRESS
Geo. F. Roth	1735 Harford

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44320

CERTIFICATE OF DEATH

90 E 44320

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 5119 Eastern ave ST. 76-37 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alexia Herrmanns

(a) RESIDENCE NO. 5119 Eastern ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carl Herrmanns,

6 DATE OF BIRTH (month, day, and year) Feb. 24-1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	-	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER dont know

11 BIRTHPLACE OF FATHER (city or town) (State or country) dont know

12 MAIDEN NAME OF MOTHER dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) dont know

14 Informant Mrs Geo N. Heck

(Address) 5119 Eastern ave

Filed 3 22 1929, 19 [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20-1929

17 I HEREBY CERTIFY, That I attended deceased from Mar 1, 1929, to Mar 20, 1929, that I last saw her alive on Mar 20, 1929 and that death occurred, on the date stated above, at 12 30 P. m.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis

(duration) Gradual yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) Gradual yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Horace B Tilson, M. D.

3/20, 1929 (Address) 310 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oaklawn Cemetery	Mch 23 1929
20 UNDERTAKER George W. Zirkler	ADDRESS 1737 E. Eager st.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44321

CERTIFICATE OF DEATH

31 ✓ E 44321

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Pennington ave. & Church St., 25 - 17 WARD)

2—FULL NAME Frederick Nehls

(a) RESIDENCE NO. Pennington ave & Church St. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): 1875

7 AGE — Years: 54 | Months: | Days: | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): Grocery Store

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Europe

PARENTS

10 NAME OF FATHER: John Nehls

11 BIRTHPLACE OF FATHER (city or town) (State or country): Europe

12 MAIDEN NAME OF MOTHER: Frances Spronk

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Europe

14 Informant: Mrs. John Stube
(Address) 1609 Cedon St.

15 Filed ..., 19... [illegible] Registrar

2 2 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 21-1929

17 I HEREBY CERTIFY, That I attended deceased from Mar 17, 19 29, to March 20, 19 29, that I last saw him alive on March 20, 19 29 and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonary Tuberculosis

(duration) 10+ yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical findings

(Signed) A. V. Mulmes, M. D.

3/21, 19 29 (Address) 37 S. Stricker St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery — DATE OF BURIAL: March 23 1929

20 UNDERTAKER: M. L. Flynn — ADDRESS: 1722 Light St

Cor.—12-9-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44322

CERTIFICATE OF DEATH.

89 E 44322

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1313 East Pratt Street St., 14-24 Ward)

2-FULL NAME Michael Glowacki

(a) RESIDENCE NO. 1313 East Pratt St St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lunch Room

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Poland

(State or country)

PARENTS

10 NAME OF FATHER Joseph Glowacki

11 BIRTHPLACE OF FATHER (city or town) Poland

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Poland

(State or country)

14 Informant Casmier Glowacki

(Address) 1420 Richardson st

15 C. HAMPSON JONES, M. D.

Registrar

Date 2 2 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 21 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) Sudden yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) James M Fenlon M. D.

(Coroner)

3 21 1929 (Address) 704 Cathedral st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cemetery Date of Burial march 23 1929

20 UNDERTAKER George A. Weber ADDRESS 705 S. Ann st.

very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44323 ✓ 57 E 44323

CERTIFICATE OF DEATH

1—PLACE OF DEATH Balto City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. 5-9 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph C. Bush

(a) RESIDENCE NO. 10 N. Spring St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Lucy Beale

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Records of

(Address) Baltimore City Hospitals

15 Filed ..., 19 HARRISON JONES, Registrar

22 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 17, 1929

17 I HEREBY CERTIFY, That I attended deceased from January 26, 19 29, to March 17, 19 29, that I last saw him alive on March 17, 19 29 and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

CONTRIBUTORY (Secondary) Bronchopneumonia, (duration) yrs. mos. ds.

Acute (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical + X-ray + Lab

(Signed) BALTIMORE CITY HOSPITALS, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart DATE OF BURIAL 3/22, 19 29

UNDERTAKER John J. Fahey Sons ADDRESS 1318 Light St

Cor.—12-9-25—A Co.—200 Bks.

(Dimarino)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44324

CERTIFICATE OF DEATH.

185

E 44324

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hospital St. 17 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Rose Dimarino

(a) RESIDENCE NO. 637 S Decker ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 41 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? 41 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Femal

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE: about 74 Years ____ Months ____ Days ____ IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work

(b) General nature of industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer

9 BIRTHPLACE (city or town) ____

(State or country) Italy

PARENTS

10 NAME OF FATHER Constantine Dimino

11 BIRTHPLACE OF FATHER (city or town) ____

(State or country) Italy

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) ____

(State or country) Italy

14 Informant Nicholas Vandamarino

(Address) 2407 S Decker ave

15 Filed 2 2 1926 C. HANSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 21 1926

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows: Fracture R. Thigh & R. Pneumonia Accident

(duration) ____ yrs. ____ mos. 3 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) ____ yrs. ____ mos. 3 ds.

(Signed) James M Fenlon, M. D. (Coroner)

3 22 1926 (Address) 700 Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents Only)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. 41 mos. ____ ds.

Where was disease contracted, if not at place of death? 637 S Decker ave

Former or usual residence 637 S Decker ave

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Date of Burial: Mar 25 29

20 UNDERTAKER: Randall & Hopped ADDRESS: 300 S Eden

very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44325

CERTIFICATE OF DEATH

129 E 44325

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 309 S. Chapel ST. 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lukasz Turek

(a) RESIDENCE NO. 309 S. Chapel St. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Turek

6 DATE OF BIRTH (month, day, and year) Nov. [illegible]. 11 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	6	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Conrad Turek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mary Turek

(Address) 309 S. Chapel St.

15 Filed 2 2 1929 19 C. HARRISON Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21 1929

17 I HEREBY CERTIFY, That I attended deceased from 3-10, 19 29, to 3-21, 19 29, that I last saw him alive on 3-21, 19 29, and that death occurred, on the date stated above, at 6:30 m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

Tuberculosis

Arteriosclerosis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Acute Chronic Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) [illegible] M.D.

(Address) 800 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary March	25 1929
20 UNDERTAKER	ADDRESS
John M Weber	1018 Chester

Spec.—2-29-28—L. F. S.—500 Blks.

E 44326

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44326

CERTIFICATE OF DEATH

90

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2501-W. North Ave. ST., 15-68 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Louise Baldinger Steyert

(a) RESIDENCE NO. 2501-W-North Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 34 yrs. ? mos. ? ds. How long in U. S., if foreign birth? 63 yrs. 7 mos. 7 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Julius Steyert

6 DATE OF BIRTH (month, day, and year): Aug-15-1865

7 AGE — Years: 63 | Months: 7 | Days: 7 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Pittsburgh Penna

PARENTS

10 NAME OF FATHER: Jacob Baldinger

11 BIRTHPLACE OF FATHER (city or town) (State or country): ??? Switzerland

12 MAIDEN NAME OF MOTHER: Anna Koenig

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ??? Switzerland

14 Informant: Mr. Julius Steyert (husband)

(Address) 2501-W-North Ave.

15 Filed 2 1929 Per C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar. 22-1929

17 I HEREBY CERTIFY, That I attended deceased from Mar 17, 1929, to Mar 21, 1929, that I last saw her alive on Mar 21st, 1929, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Myocarditis (rheumatic)
Aortic dilatation of
heart.

(duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary): Chronic Arthritis

(duration) 10 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam'n

(Signed) S. R. Dodd, M. D.

Mar 22, 1929 (Address) 904 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pittsburgh-Pa. DATE OF BURIAL: Mar 23 1929

20 UNDERTAKER: Stewart Funeral ADDRESS: Balto.

Spec.—2-29-28—L. F. S.—500 Bks.

E 44327

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001

E 44327

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. 425 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Wong Lee Took

(a) RESIDENCE NO. 208 W. Fayette 1 ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Yellow

5 ~~Single~~, Married, Widowed, ~~or Divorced~~, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Chu Shee

6 DATE OF BIRTH (month, day, and year): 1903

7 AGE: Years 26 | Months — | Days — | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laundryman
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): China

PARENTS

10 NAME OF FATHER: Wong Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country): China

12 MAIDEN NAME OF MOTHER: Leung Shee

13 BIRTHPLACE OF MOTHER (city or town) (State or country): China

14 Informant: Baltimore City Hospitals
(Address)

15 Filed MAR 22 1929, 19 C. HARRISON JONES, M. D.
Per AKA Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/22/29

17 I HEREBY CERTIFY, That I attended deceased from March 8, 1929, to March 22, 1929, that I last saw h[illegible] alive on March 22, 1929 and that death occurred, on the date stated above, at 4 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial Failure
Pulmonary Bronchopneumonia
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Manic Depressive Psychosis Depressed Phase
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical History Findings

(Signed) Harry G. Edmonds, M. D.

3-22-29 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Mar 24 1929
20 UNDERTAKER	ADDRESS
Stewart & Moore Co	1st & Wash.

Spec.—2-29-28—L. F. S.—500 Bks.

Dr Walter 1500 N Broadway

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44328

CERTIFICATE OF DEATH

90 E 44328

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 414 N Carolina ST., 5 4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank Frei

(a) RESIDENCE NO. 414 N Carolina ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elizabeth Frei

7 DATE OF BIRTH (month, day, and year): Apr 27, 1865

8 AGE: Years 63 | Months 10 | Days 25 | If LESS than 1 day, hrs. or min.

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Clemmens Rough

10 BIRTHPLACE (city or town) (State or country): Baltimore Md

11 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

Informant: Elizabeth Frei

(Address) 414 N Carolina St

Filed 3/24 1929 C. H. HANSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar. 21. 1929

17 I HEREBY CERTIFY, That I attended deceased from 3/17, 1929, to 3/21, 1929, that I last saw him alive on 3/21, 1929, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Aortic Insufficiency

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) Dane Miller, M. D.

3/22, 1929 (Address) 1500 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem

DATE OF BURIAL: 3/23 1929

20 UNDERTAKER: W M Cook

ADDRESS: 1217 E Fayette St

Spec.—2-29-28—L. F. S.—500 Bks.

223365
E 44329

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X23 E 44329

1—PLACE OF DEATH

JOHNS HOPKINS HOSP.

CITY OF BALTIMORE: (No. ..... ST. 19 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Clevey Cline

(a) RESIDENCE NO. 916 S. Jackson ST. St WARD Salisbury N Car
(Usual place of abode)

Length of residence in city or town where death occurred — yrs. — mos. 9 ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 16, 1917

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
12	0	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Schoolboy

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): N - Car -

10 NAME OF FATHER: John P. Cline

11 BIRTHPLACE OF FATHER (city or town) (State or country): N - Car -

12 MAIDEN NAME OF MOTHER: Mayme Hoke

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N - Car -

14 Informant: Friends -

(Address) YOUNG WORKING

15 Filed 2-27-29, 19 (CHARLTON JONES M.D.) Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3 22 29

17 I HEREBY CERTIFY, That I attended deceased from March 18, 1929, to March 22, 1929

that I last saw him alive on March 22, 1929

and that death occurred, on the date stated above, at 1 22 P. m.

The CAUSE OF DEATH* was as follows:

Encephalitis

(duration) 0 yrs. 1 mos. 0 ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Salisbury. N.C.

Did an operation precede death? No. Date of

Was there an autopsy? Yes - (Head)

What test confirmed diagnosis? Sp F.

(Signed) Oskar Diethelm, M. D.

3 - 27. 1929 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Salisbury, N. C

DATE OF BURIAL: 3 23 29

20 UNDERTAKER: [illegible] (Cox)

ADDRESS: 1217 E Pratt St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44330

CERTIFICATE OF DEATH

11-001

E 44330

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1448 ward ST. 21-26 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME David Bryan

(a) RESIDENCE NO. 1448 ward ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	col	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 7/28

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	mo	2	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Sylvester Bryan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Corine Weil

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Corine Bryan

(Address) 1448 ward

Filed 3-23 1929, 19 HAMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22/28

17 I HEREBY CERTIFY, That I attended deceased from Dec 26, 1927, to March 22, 1928, that I last saw he alive on March 21, 1928 and that death occurred, on the date stated above, at 6:20 a. m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) yrs. mos. 18 ds.

CONTRIBUTORY (Secondary) Bronchial pneumonia

(duration) 4d yrs. mo mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Presumed Rales

(Signed) Raymond Glaun, M. D.

March 22 1928 (Address) Parkton Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem DATE OF BURIAL 3-23 1928

UNDERTAKER Samuel Carter ADDRESS Balto

Spec.—2-29-28—L. F. S.—500 Bks.

E 44331

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 44331

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1211 Valley ST.) 10-14 (WARD) REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna K. Luber

(a) RESIDENCE NO. 1211 Valley St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 76 yrs. 8 mos. 8 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city, town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

a If married, widowed, or divorced — ~~HUSBAND of~~ (or) WIFE of late George M. Luber

6 DATE OF BIRTH (month, day, and year) July 13 1852

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
76	8	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER Wm. Maurer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

PARENTS

Informant Mr. George W. Jos. Luber

(Address) 1211 Valley St.

Filed 2-29 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21 1929

17

I HEREBY CERTIFY, That I attended deceased from 3/8, 1929, to 3/21, 1929, that I last saw h alive on 3/26, 1929 and that death occurred, on the date stated above, at 11.45 a.m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

Arteriosclerosis

Uremia (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr. Leonard Wess, M. D.

3/1/29 (Address) 1216 E. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: March 25 1929

20 UNDERTAKER: Henry Arndt Sons Inc. — ADDRESS: 1301 E. Eager St.

Spec.—2-29-28—L. F. S.—500 Bks.

E 44332

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44332

CERTIFICATE OF DEATH

49

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital ST. 16-17 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph Stumpfel Registry.

(a) RESIDENCE NO. 4205 Parkmont Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. — mos. — ds. How long in U. S., if foreign birth 29 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Elizabeth Stumpfel

6 DATE OF BIRTH (month, day, and year) Dec. 29 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	3	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker in business

(b) General nature of industry, business, or establishment in which employed (or employer) for himself 003

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Stumpfel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Marie Paul

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Elizabeth Stumpfel

(Address) 4205 Parkmont Ave

15 Filed 3 1929, 19 HAMPSON JONES M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 17, 1929, to March 22, 1929, that I last saw h— alive on March 22, 1929, and that death occurred, on the date stated above, at 5:35 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma ? prostate

(duration) 12 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) — yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Examination

(Signed) F. A. Evangelisti, M. D.

3/22, 1929 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	March 26 1929
20 UNDERTAKER	ADDRESS
Henry Meech Sons, Inc.	1531 E Eager St

Spec.—2-29-28—L. F. S.—500 Bks.

E 44333

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

123

E 44333

REGISTERED NO. 76-37

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 319 S. Macon ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret Seibert.

(a) RESIDENCE NO. 319 S. Macon ST., 26 WARD
(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Joseph H. Seibert

6 DATE OF BIRTH (month, day, and year) Nov. 5 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	4	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germany
(State or country)

PARENTS

10 NAME OF FATHER John Wicher

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Mary Ritter

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Mrs. Constance Seibert

(Address) 318 S. Mason St.

15 FILED MAR 23 1929, 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan, 1926, to March 22, 1929, that I last saw h alive on March 22, 1929 and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Biliary Calculi

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Nephritis.

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Otto J. Schmalling M. D.

, 19 (Address) 451 E Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem	Mch 26 1929
20 UNDERTAKER Lilly & Sons Inc	ADDRESS 103 S. Wolfe St

Spec.—2-29-28—L. F. S.—500 Blks.

E 44334 HEALTH DEPARTMENT—CITY OF BALTIMORE

Tracey

118-002

E 44334

CERTIFICATE OF DEATH

1—PLACE OF DEATH Union Memorial Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. 12-49 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Willis F. Tracey

(a) RESIDENCE NO. Manchester Md ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 31, 1860

7 AGE — Years: 68 | Months: 11 | Days: 23 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Miller

(b) General nature of industry, business, or establishment in which employed (or employer): Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Pennsylvania

PARENTS

10 NAME OF FATHER: John W. Tracey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Margaret Wentz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa.

14 Informant: Jacob R. L. Wink

(Address) Manchester Md

15 Filed 23 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/23/29

17 I HEREBY CERTIFY, That I attended deceased from March 20, 19 29, to March 23, 19 29, that I last saw him alive on March 23, 19 29, and that death occurred, on the date stated above, at 5:55 A m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Manchester Md.

Did an operation precede death? Yes Date of March 21, 1929

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature] M. D.

19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lineboro, Md., DATE OF BURIAL: March 26th 1929

20 UNDERTAKER: Jacob Wink's Sons ADDRESS: Manchester Md

Spec.—2-29-28—L. F. S.—500 Blks.

E 44335 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

37-001 E 44335

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 526 N. Dallas ST., 5-9 WARD)

2—FULL NAME Virginia Thompson

(a) RESIDENCE NO. 526 N. Dallas ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Col.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Thompson

6 DATE OF BIRTH (month, day, and year) —1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER Catherine Kelly

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Virginia

14 Informant John Thompson (Address) 526 N. Dallas

Filed 3-23-1929, 19 C. HAMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 20. 29

17 I HEREBY CERTIFY, That I attended deceased from Mar. 14, 1929, to Mar 20, 1929, that I last saw h. alive on Mar 20, 1929, and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart
Enteritis, Possible acute
miliary Tuberculosis

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Acute myocarditis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. Dx

(Signed) W. L. J Berry, M. D.

19 (Address) 1430 E. Cold

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Richmond Co Va	Mar. 24 1929

20 UNDERTAKER ADDRESS

Robert E. Williams 1515 M[illegible]

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44336

CERTIFICATE OF DEATH

49-E 44336

1-PLACE OF DEATH

City of Baltimore: (No. 1534 N. Bond St St. 8-17 Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Fred. Black

(a) RESIDENCE NO. 1534 N. Bond St St.. Ward .....

(Usual place of abode) life (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	widower

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Kate Josephine Black

6 DATE OF BIRTH (month, day, and year) Dec 20-56

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	72	3	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Real Estate Dealer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer Self

9 BIRTHPLACE (city or town) Balto., Md.
(State or country)

PARENTS

10 NAME OF FATHER Harman F. Black

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary A. ------

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Germany

14 Informant Elizabeth S. McCullough
(Address) 1534 N. Bond St

15 Filed 19.. C. HARRISON JONES, M. D. Registrar

23 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 21/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Carcinoma of Larynx

..... (duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..yrs. ..mos. ..ds.

18 Where was disease contracted If not at place of death? .....

Did an operation precede death? yes Date of Oct 6/28

Was there an autopsy? Resection of Larynx

What test confirmed diagnosis? .....

(Signed) J. F. Cullen, M. D.

3/22/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto Cem	3/23 1929
20 UNDERTAKER Philip Herwig	ADDRESS 1616 Orleans

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 44337 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

12 E 44337

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 1211 Madison Ave St.) (1-7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Currie O. Edmondson

(a) RESIDENCE NO. 1211 Madison Ave St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. 3 mos. 3 ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 18 1858

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
70	3	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Teacher

(b) General nature of industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer: 968

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

10 NAME OF FATHER: James M. Edmondson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Ellen J. Tagon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mrs Ella D. Travers.

(Address) 1211 Madison Ave

15 MAR 3 1929, 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 21 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan. 31, 1929, to Mch. 21, 1929, that I last saw h.. alive on Mch. 21, 1929, and that death occurred, on the date stated above, at 10.15 P m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

Short time Suddenly

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Indigestion

(duration) About 4 hrs. yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Wm. R. Baumbaker, M. D.

, 19 (Address) 2740 St. Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem.

DATE OF BURIAL: Mar 25 1929

20 UNDERTAKER: W. H. Tucker & Sons

ADDRESS: North & Pa

Spec.—1-10-21—M&T—1500 Bks.

E 44338 HEALTH DEPARTMENT—CITY OF BALTIMORE E 44338

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4666 Pimlico Rd (ST.) (WARD) 24 45-58

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta Rosenthal

(a) RESIDENCE NO. 4666 Pimlico Rd (St.) WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 6 1853

7 AGE: Years 75 Months 6 Days 16 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Karl Rosenthal

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Charlotte Schluter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Adolph Halberstadt (Address) 4666 Pimlico Rd

15 Filed 2 3 1929 C. HAMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22 1929

17

I HEREBY CERTIFY, That I attended deceased from March 17, 1929, to March 22, 1929, that I last saw her alive on March 22, 1929, and that death occurred, on the date stated above, at 6:10 A. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

CONTRIBUTORY (Secondary) Cardio-Selerosis — duration — yrs. — mos. 5 ds.

Chr. Nephritis — duration 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Hospital Symptoms

(Signed) Louis H. Friedman M. D.

, 19 (Address) 722 E. Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery DATE OF BURIAL: Mar 25 1929

20 UNDERTAKER: John F Penny ADDRESS: 715 Light St

Spec.—2-29-28—L. F. S.—500 Bks.

E 44339

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 44339

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3501 Carlisle Ave. ST., 15-67 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Lucas Miller

(a) RESIDENCE NO. 3501 Carlisle Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Charles S. Miller

6 DATE OF BIRTH (month, day, and year) June 5, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	9	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Henry J. Michael

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah J. Michael

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Lelia E. Miller

(Address) 3501 Carlisle Ave.

15 Filed 3-23, 1929 C. HAMPSON JONES, M. D. Registrar

Per DKD

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 22/29

17 I HEREBY CERTIFY, That I attended deceased from Feb. 16th, 1929, to Mar. 22nd, 1929, that I last saw h alive on March 21st, 1929 and that death occurred, on the date stated above, at 12.05 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinary analysis & Blood pressure

(Signed) Charles Kelly, M. D.

March 24 1929 (Address) 1111 W. Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery — DATE OF BURIAL: Mar. 23 1929

20 UNDERTAKER: John O. Mitchell & Sons — ADDRESS: 1900 Eutaw Pl.

H. B. Mitchell

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44340

CERTIFICATE OF DEATH.

170 E 44340

1-PLACE OF DEATH

City of BALTIMORE: (No.) Mercy Hospital St. 1249 Ward

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Stephen Lee George

(a) RESIDENCE NO. 3943 Canterbury Road St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 26 1882

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	46	6	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Auto accessories

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Md.

(State or country): Md

PARENTS

10 NAME OF FATHER: Jno George

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Md

12 MAIDEN NAME OF MOTHER: Annabel Lee

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Md

14 Informant: Mrs. F. Kelly George

(Address): 3943 Canterbury Rd

23 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): May 22 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by pistol shot wound of brain

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Wm. F. Kelly M. D.

(Coroner)

1977 (Address) 1639 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Date of Burial May 25 1929

20 UNDERTAKER: J. O. Pfeltzer ADDRESS 1908 Eutaw Place

very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

E 44341 HEALTH DEPARTMENT—CITY OF BALTIMORE E 44341

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Woman's Hosp

CITY OF BALTIMORE: (No. 12-51 ST. 47 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Griffith Strobel

(a) RESIDENCE No. 2133 Maryland Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dr. Edgar Strobel

6 DATE OF BIRTH (month, day, and year) ?

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
51		-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Robert H. Griffith

11 BIRTHPLACE OF FATHER (city or town) (State or country) ? Md.

12 MAIDEN NAME OF MOTHER Margaret C. ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ? Md.

14 Informant Edgar Strobel

(Address) 2133 Maryland ave

15 Filed MAR 23 1929, 19 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 23 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 26, 1928, to Mar 23, 1929, that I last saw h alive on Mar 20, 1929, and that death occurred, on the date stated above, at 6 57 A m.

The CAUSE OF DEATH* was as follows:

Generalized Carcinomatosis

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) Cachexia

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Robert A. McGeary M. D.

, 19 (Address) Womans Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mound Cemetery — DATE OF BURIAL Mar. 25, 1929

UNDERTAKER John O. Mitchell & Sons — ADDRESS 1900 Eutaw Pl.

IMPORTANT: See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 44342

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44342

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 1044 N. Central Ave — 16 — REGISTERED NO. .....

CITY OF BALTIMORE: (No. ..... ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Philipp Johanni

(a) RESIDENCE NO. 1044 N. Central Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 22, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, 4 hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER Wm. J. Johanni

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Agnes E. Eisenmann

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Mother
(Address) 1044 N. Central Ave.

15 Filed ..... 19 [illegible] Registrar

3 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22 1929

17 I HEREBY CERTIFY, That I attended deceased from March 22, 1929, to ....., 19..., that I last saw h[illegible] alive on March 22, 1929, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Asphyxia Pallida

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) —

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ....."

Did an operation precede death? ....." Date of

Was there an autopsy? "

What test confirmed diagnosis? L. Sobrel

(Signed) ....., M. D.

3/22, 1929. (Address) 1044 N. Central Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL March 23 1929

20 UNDERTAKER Henry Stoeck & Sons Inc

ADDRESS 1301 E Eager St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 44343

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 4-30 WARD)

REGISTERED NO. E 44343

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sallie L. Lilly

(a) RESIDENCE NO. Elliott City ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 15 ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William F. Lilly

6 DATE OF BIRTH (month, day, and year) May 23, 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	9	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Duties Off

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER William Phipps

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Emma Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant William F. Lilly

(Address) Elliott City Md.

15 Received MAR 24 1929, 19 Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 23, 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb. 8, 19 29, to Mar. 23 19 29, that I last saw h alive on Mar. 23, 19 29 and that death occurred, on the date stated above, at 7.20 p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cervix & Uterus

Hypertension Cardio Vascular Renal Disease

CONTRIBUTORY (Secondary) Cerebral Hemorrhage (duration) yrs. 2 mos. 10 ds. (?)

18 Where was disease contracted if not at place of death? —

(duration) yrs. 1 mos. 6 ds.

Did an operation precede death? Yes Date of 2 | 9 | 29

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Luther E. Linde, M. D.

19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

20 UNDERTAKER Carroll M. Stem Ellicott City

DATE OF BURIAL Mar. 26 19 29

ADDRESS

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 44344

E 44344

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 640 W. Lombard St., 4-30 Ward)

2-FULL NAME Robert Rudkins

(a) RESIDENCE NO. Guilford, Howard Co., Md. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 14. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary M. Rudkins

6 DATE OF BIRTH (month, day, and year) Nov. 17, 1866

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
62	4	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Stone Cutter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) England.

PARENTS

10 NAME OF FATHER Frederick Rudkins

11 BIRTHPLACE OF FATHER (city or town)
(State or country) England

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Thomas L. Rudkins
(Address) Jessups, Md. R. F. D.

15 Filed APR 24 1929 C. HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Angina Pectoris

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zellers, M. D.

, 19 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Howard County Guilford M. E. Church Cem. | DATE OF BURIAL 3/25, 1929

20 UNDERTAKER Easton & Sons | ADDRESS City. Ellicott

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 44345 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44 E 44345

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2040 W. Fayette ST., 20-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret A. Covington

(a) RESIDENCE NO. 2040 W. Fayette ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Femele	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Walter B. Covington

6 DATE OF BIRTH (month, day, and year) Oct. 6, 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53	5	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 0 3 1

(c) Name of employer At Home

9 BIRTHPLACE (city or town) (State or country) Gloucester County Virginia

PARENTS

10 NAME OF FATHER Carter B. Williams

11 BIRTHPLACE OF FATHER (city or town) Gloucester (State or country) Virginia County

12 MAIDEN NAME OF MOTHER Alice Williams

13 BIRTHPLACE OF MOTHER (city or town) Gloucester (State or country) Virginia

14 Informant Mr. W. B. Covington

(Address) 2040 W. Fayette St.

15 Filed MAR 24 1929, 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 12th 28, 19..., to March 22, 19 28, that I last saw her alive on March 21, 19 29 and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) asthenia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Roy O'McCreary, M. D.

3/23 19 29 (Address) 400 N. Peyson Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Church View, Virginia — DATE OF BURIAL Mar. 24 19 29

20 UNDERTAKER Joseph Cook — ADDRESS 1003 W. Baltimore St

Spec.—2-29-28—L. F. S.—500 Bks.

E 44346

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

154 E 44346

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1922 W Baltimore ST. 10-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Emma Zimmermann

(a) RESIDENCE NO. 1922 W. Baltimore ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas Zimmerman

6 DATE OF BIRTH (month, day, and year) Dec 20 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
56	57	2 3	21 2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Jacob Munsch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Switzerland

12 MAIDEN NAME OF MOTHER Barthea Bader

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr Chas Zimmerman

(Address) 1922 W Baltimore

15 Filed APR 24 1929 H. E. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23. 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1929, to March 23 1929, that I last saw h alive on March 22, 1929 and that death occurred, on the date stated above, at 6.30 A.m.

The CAUSE OF DEATH* was as follows:

Septicemia

CONTRIBUTORY (Secondary) Pemphigus Vulgaris (duration) yrs. 5 mos. ds.

(duration) 4 yrs. mos. ds.

18 Where was disease contracted If not at place of death? Yes

Did an operation precede death? No! Date of

Was there an autopsy? No!

What test confirmed diagnosis? Clinical

(Signed) John A Evans, M. D.

3/23. 1929 (Address) 612 W 40 St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Mar. 25 19 29

20 UNDERTAKER A B Brook

ADDRESS 1003 West Baltimore St

Spec.—12-9-25—A Co.—200 Bks.

E 44347

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 44347

REGISTERED NO. 39

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Church Home & Infirmary Ward

2-FULL NAME Laura V Pfeiffer

(a) RESIDENCE NO. 1 N. Monroe St St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): August 16, 1869

7 AGE

Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
59	7	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Catonsville

(State or country): Maryland

PARENTS

10 NAME OF FATHER: George Frederick Pfeiffer

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Maryland

12 MAIDEN NAME OF MOTHER: Elizabeth M. Collins

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Maryland

14

Informant: Herbert N. Von Wachter

(Address): 1 N. Monroe Street

Filed MAR 24 1929 19

WILSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/22/1929

17

I HEREBY CERTIFY, That I attended deceased from 3/17, 1929, to 3/22, 1929, that I last saw h.. alive on 3/22/29, 1929, and that death occurred, on the date stated above, at 11.50 A.M.

The CAUSE OF DEATH* was as follows:

Myoma uteri

CONTRIBUTORY (Secondary): Acute cardiac dilatation (duration) 10 yrs. mos. ds. — 1/2 hour

18 Where was disease contracted (duration) yrs. mos. ds.

If not at place of death?

Did an operation precede death? Yes Date of 3/18/29

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Edward J. Buehler M. D.

3/22 1929 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — Date of Burial: Mar. 25 1929

20 UNDERTAKER: J. A. Block — ADDRESS: 1003 West Baltimore St.

very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

44348

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-902 E 44348

CERTIFICATE OF DEATH

BALTIMORE CITY HOSPITALS [redacted]

1—PLACE OF DEATH REGISTERED NO.

CITY OF BALTIMORE: (No. 22-30 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sarah Sutton (Janie Sarah)

(a) RESIDENCE NO. 120 W Dover ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 870

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Lewis Leoman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Information furnished by Records of BALTIMORE CITY HOSPITALS
(Address) [redacted]

15 Filed MAR 24 1929 HARRY H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20, 1929

17 I HEREBY CERTIFY, That I attended deceased from February 18, 1929, to March 20, 1929, that I last saw her alive on March 20, 1929, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Senility
Gastroenterostomy
Cystitis Pulmonary Oedema

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis Clinical Symptoms

(Signed) H. M. Wich M. D.

, 19 (Address) BALTIMORE CITY HOSPITALS [redacted]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
White Rock Md	Mar 24 1929
20 UNDERTAKER	ADDRESS
Leard & Wall	698 Pierce

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44349

CERTIFICATE OF DEATH

90 E 44349

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS [redacted]

CITY OF BALTIMORE: (No. [redacted] ST., 3-5 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Michael Helesy

(a) RESIDENCE NO. 1032 E. Lombard ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred [illegible] mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(if non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Michael Helesy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Mary Garber

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Records of BALTIMORE CITY HOSPITALS [redacted]

15 Filed [redacted], 19 [redacted] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 20, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 9, 1929, to March 20, 1929, that I last saw him alive on March 20, 1929, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Chr. myocarditis

Paroxysmal tachycardia

(duration) 1 yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Myocardial degeneration

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [redacted] M. D.

19 (Address) BALTIMORE CITY HOSPITALS [redacted]

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart

DATE OF BURIAL 3/22/29

20 UNDERTAKER John J Fahey Son

ADDRESS 1318 Light St

Spec.—1-12-23—M&T—500 Bks.

E 44350 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

46 E 44350

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital St. 70-69 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME 2504 Christian St

(a) RESIDENCE NO. Mrs Matilda Hilgeman ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George

6 DATE OF BIRTH (month, day, and year) Aug 10. 1873

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
55	7	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Hm Eckert Md.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Christe Zand

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant George Hilgeman (Address) 2504 Christian St

15 Filed APR 24 1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-22 1929

17 I HEREBY CERTIFY, That I attended deceased from 3-13, 1929, to 3-22, 1929, that I last saw h[illegible] alive on 3-22, 1929, and that death occurred, on the date stated above, at 12-30 P m.

The CAUSE OF DEATH* was as follows: Carcinoma, mort probably Ovarian Carcinoma.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Lucius Lancelot Daniels, M. D.

, 19 (Address) 1 Hilgeman Terrace

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, (Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western DATE OF BURIAL Mar 25 29

20 UNDERTAKER J. McCook ADDRESS 1217 St Paul St.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44351 — CERTIFICATE OF DEATH — 31 E 44351

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No.) Baltimore City Hospitals (ST. B. WARD) 617

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Steinbaugh (Stinebaugh)

(a) RESIDENCE NO. 1507 E. Hoffman st. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edith Steinbaugh

6 DATE OF BIRTH (month, day, and year) June 13 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	9	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Steinbaugh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Loman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records
(Address)

MAR 24 1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 7, 1929, to March 23, 1929, that I last saw him alive on March 23, 1929 and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage (duration) Immediately

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical and lab.

(Signed) Tony Smith, M. D.

3-23, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore — DATE OF BURIAL 3/26/29

20 UNDERTAKER W. M. Cook — ADDRESS 217 N. Paul St

Spec.—2-29-28—L. F. S.—500 Bks.

MARTIN Dr E 13 Fenby 1221 N Caroline

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44352

CERTIFICATE OF DEATH

5 V E 44352

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 5106 Belmore Way ST., 27-41 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Julia C Martin

(a) RESIDENCE NO. 5106 Belmore Way ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel A Martin

6 DATE OF BIRTH (month, day, and year) Jan. 21, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) Baltimore Md

(State or country)

10 NAME OF FATHER Wm H. Glenn

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md

(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Watkins

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md

(State or country)

14 Informant Lynn Howard

(Address) 8 South East Ave

MAR 24 1929 H. W. Jones, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 23. 1929

17 I HEREBY CERTIFY, That I attended deceased from April 30-, 1928, to Mar. 23-, 1929, that I last saw her alive on Mar. 22-, 1929 and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Arthritis Deformans

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edwin B. Fenby, M. D.

3/23/1929 (Address) 1223 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Union Fork

DATE OF BURIAL 3/26 1929

UNDERTAKER J M Cole

ADDRESS 217 E Lanvale

Spec.—2-29-28—L. F. S.—500 Bks.

Dr Walter White 1101 ½ Broadway

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44353

CERTIFICATE OF DEATH

3/ E 44353

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2309 E. Biddle ST. 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emmie E Gibbons

(a) RESIDENCE NO. 2309 E. Biddle ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 14, 1909

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
19	6	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stenographer

(b) General nature of industry, business, or establishment in which employed (or employer) 009

(c) Name of employer H. K. Martin

9 BIRTHPLACE (city or town) Belmont
(State or country) Va

10 NAME OF FATHER Thos J Gibbon

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Annie Scott

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Emmie Gibbons
(Address) 2309 E. Biddle St

15 Filed MAR 24 1929 HAMPTON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 23. 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 16, 1928, to Mar. 23, 1929, that I last saw h er alive on Mar 23, 1929 and that death occurred, on the date stated above, at 10 30 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

3/24, 1929 (Signed) G W White, M. D.
(Address) 280 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Annancock Va

DATE OF BURIAL: 3/26 1929

20 UNDERTAKER: J H Cook

ADDRESS: 121 S Eutaw St

Spec.—2-29-28—L. F. S.—500 Bks.

Dr Forsythe, 1st Footchm

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44354

CERTIFICATE OF DEATH

65-001

E 44354

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 214 East 20th St. 12-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jane L. Worrall

(a) RESIDENCE NO. 214 East 20th ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Clara C. Forrest

6 DATE OF BIRTH (month, day, and year) Dec 14 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	11	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real Estate

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Jane L. Worrall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Jas

12 MAIDEN NAME OF MOTHER Sarah Wallace

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Clara Forrest

(Address) 214 East 20th St

15 MAR 24 1929 Wm H. JONES, M. D.

(Registrar)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22. 1929

17 I HEREBY CERTIFY, That I attended deceased from March 21, 1929, to March 22, 1929, that I last saw him alive on March 21, 1929 and that death occurred, on the date stated above, at 4-a, m.

The CAUSE OF DEATH* was as follows:

Leukemia (?)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Nasal hemorrhages at various times

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No.

(Signed) Hugh Forsythe, M. D.

3-23, 1929 (Address) 424 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL North East, Md

DATE OF BURIAL 3-1 1929

20 UNDERTAKER W. M. Cook

ADDRESS 1214 E Fayette

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44355

CERTIFICATE OF DEATH.

49 E 44355

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital ST. 7-13 WARD)

2-FULL NAME Isaac Polonsky.

(a) RESIDENCE NO. 2007 Eagle St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? 12 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Bailey Polonsky

6 DATE OF BIRTH (month, day, and year):

7 AGE: Years 77 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER:

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER:

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Jack Lewis 1439 E. Balto St.

MAR 24 1929, C. HAMILTON JONES, M.D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/24 1929

17

I HEREBY CERTIFY, That I attended deceased from 3/23, 1929, to 3/24, 1929,

that I last saw h alive on 3/23, 1929,

and that death occurred, on the date stated above, at 5:59 p.m.

The CAUSE OF DEATH* was as follows:

Uraemia.

Carcinoma of Rectum.

(duration) — yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) J. E. Goodman, M. D.

3/24, 1929 (Address) Sinai Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Sinai Rodef Sholom

DATE OF BURIAL: 3/24 1929

UNDERTAKER: Jack Lewis

ADDRESS: 1439 E. Balto

Spec.—2-29-28—L. F. S.—500 Bks.

E 44356

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 44356

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH Provident Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1514 Division ST. 14-27 WARD)

2—FULL NAME James Wallace

(a) RESIDENCE NO. 204 N Stricker ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Colored	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	—	6	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt. Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records

(Address)

15 Filed MAR 24 1929, HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23, 1929

17 I HEREBY CERTIFY, That I attended deceased from 3-21- 1929, to March 23, 1929

that I last saw h/m alive on March 23, 1929

and that death occurred, on the date stated above, at 3 05 A m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Undetermined

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Path. & Blood Culture

(Signed) B. Fraser M. D.

3/23 1929 (Address) Provident Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary Cemtery

DATE OF BURIAL 3/24 1929

20 UNDERTAKER Walter B. Spriggs

ADDRESS 184 W. Hamburg St.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44357

CERTIFICATE OF DEATH

E 44357
REGISTERED NO.

1-PLACE OF DEATH Mercy Hospital

City of BALTIMORE: (No. 12-50 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James E. Tate

(a) RESIDENCE NO. 2822 N. Calvert St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred – yrs. 3 mos. – ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lela J. Tate

6 DATE OF BIRTH (month, day, and year) Nov 30 1863

7 AGE	Years	Months	Days	IF LESS than 1 day ___ hrs. or ___ min..
	65	3	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mgr Cotton Mill

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Anne Arundel Co. Md

(State or country)

PARENTS

10 NAME OF FATHER John Joseph Tate

11 BIRTHPLACE OF FATHER (City or town) Anne Arundel Co Md

(State or country)

12 MAIDEN NAME OF MOTHER Mary Gilley

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maine

14 Informant Mrs Lela J. Tate

(Address) 2822 N Calvert St

Filed MAR 24 1929 C. H. [illegible], M. D. Registrar

Per [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-22-29 19

17 I HEREBY CERTIFY, That I attended deceased from 2-19, 1929, to 3-22, 1929,

that I last saw him alive on 3-22, 1929,

and that death occurred, on the date stated above, at 4 PM.

The CAUSE OF DEATH* was as follows:

Carcinoma head of pancreas with metastases

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Emaciation, Exhaustion, Myocardial failure (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Nov. 1928

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) F. W. Tillen, M. D.

. 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
London Park Cemetery	March 25 1929
20 UNDERTAKER	ADDRESS
[illegible] Black 74 E. Northern	

very important. See instructions on back of certificates.

Be sure to state in full the occupation of every person, whether employed or not. If a housewife, so state; if a laborer, specify what kind of labor he usually performed; if a clerk in a store, state what kind of store; if a salesman, state what he sold; if a manufacturer, state what he manufactured; if a mechanic, state what trade he followed; if a farmer, state whether he owned the farm or worked as a tenant; if a child, state what school he attended. Exact statement of OCCUPATION is

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44358

CERTIFICATE OF DEATH

101-001

E 44358

1—PLACE OF DEATH Lorendale Belvedere ave

CITY OF BALTIMORE: (No.) Hebrew Aged Home (ST.) 27-54 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Meyer. M. Land

(a) RESIDENCE NO. Hebrew Aged Home

(Usual place of abode) WARD

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? 30 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Wid.

a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah

6 DATE OF BIRTH (month, day, and year): 1863

7 AGE — Years: 66 — Months: — Days: — If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Simon Land

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Bessie Choyett

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: L Land

(Address): 207 Bryant ave

15 Filed MAR 24 1929 WILSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 23/29

17 I HEREBY CERTIFY, That I attended deceased from March 21 1929 to March 23 1929 that I last saw him alive on March 23 1929 and that death occurred, on the date stated above, at 10.9 m.

The CAUSE OF DEATH* was as follows:

Cerebral Artesio Sclerosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Herman Seidl, M. D.

3/24 1929 (Address) 2404 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale

DATE OF BURIAL: 3/24 1929

20 UNDERTAKER: Sol Levinson & Bro

ADDRESS 1127 E Balto st

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 44359 44 E 44359

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1820 Ashburton ST. 15-68 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Bridget Deveney.

(a) RESIDENCE NO 1820 Ashburton ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Michael Deveney.

6 DATE OF BIRTH (month, day, and year) Feb. 10-1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	1	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) " "

12 MAIDEN NAME OF MOTHER E. Grogan.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Thos. F. Deveney

(Address) 1820 Ashburton Ave

15 [illegible] JONES, M. D.

R24 1929 [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 21 29

17 I HEREBY CERTIFY, That I attended deceased from Dec-1, 1928, to 3-21-, 1929.

that I last saw h[illegible] alive on 3-21-, 1929

and that death occurred, on the date stated above, at 10.25 P. m.

The CAUSE OF DEATH* was as follows:

Cerebro sclerosis with hypertension -

Pharyngeal carcinoma.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Myocarditis.

(duration) 1 yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) S. Edmunds M. D.

3-24, 1929 (Address) Medical Arts Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Vincents Cem	Mar 25 1929
20 UNDERTAKER	ADDRESS
Geo M. Fritz & Son	811 N Wolfe

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44360 1-PLACE OF DEATH

E 44360

REGISTERED NO.

CITY OF BALTIMORE: (No. 1229 Mt. Royal Ave. ST., 11-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Helen Lilly

(a) RESIDENCE NO. 1229 Mt. Royal Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 77 yrs. 11 mos. 24 ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry J. Lilly

6 DATE OF BIRTH (month, day, and year) March 28, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77	11	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Edward F. Jenkins

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah C. Jenkins

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mr. Geo. C. Lilly

(Address) 1725 Bolton Street

15 Filed APR 24 1929, HARRY JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22, 1929

17

I HEREBY CERTIFY, That I attended deceased from March 20, 1929, to March 22, 1929, that I last saw him alive on March 22, 1929, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cholecystitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 4 hrs ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. H. Hayward, M. D.

3/23, 1929. (Address) 1129 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Long Green Md.	3/25 19 29
UNDERTAKER Henry U. Meades and Son	ADDRESS 805 N Calvert

Spec.—1-10-21—M&T—1500 Bks.

E 44361 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

139 E 44361

REGISTERED NO.

1-PLACE OF DEATH Women's Hospital

CITY OF BALTIMORE: (No. 6-10 St.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Sallie Struve

(a) RESIDENCE NO. 19 North Milton ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of C. D. Struve

6 DATE OF BIRTH (month, day, and year) June 26-1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	52 years	8	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dress maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mathews Virginia

PARENTS

10 NAME OF FATHER C. H. Drake

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mathews, Virginia

12 MAIDEN NAME OF MOTHER Laura B Richards

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mathews Virginia

14 Informant (Address) Mrs Laura B Graves 3103 Fleetwood Ave

15 Filed ..... 19 ..... Per HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23 1929

17

I HEREBY CERTIFY, That I attended deceased from March 18, 1929, to March 23 1929, that I last saw h alive on March 23, 1929, and that death occurred, on the date stated above, at 5:45 A m.

The CAUSE OF DEATH* was as follows:

Myomata uteri

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of March 17, 29

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas G. Woodyer M. D.

19 (Address) Women's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore Cemetery — DATE OF BURIAL Mar 25th 29

UNDERTAKER Ketcham Bros — ADDRESS 1723 N Eutaw

IMPORTANT: See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 44362 HEALTH DEPARTMENT—CITY OF BALTIMORE E 44362

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4014 Dorchester Road (St.) 15-63 (Ward) 90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence M. McKenna

(a) RESIDENCE NO. 4014 Dorchester Road (St.) WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W.

5 ~~Single~~, Married, Widowed, or ~~Divorced~~, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm J. McKenna

6 DATE OF BIRTH (month, day, and year) July 20th 1878

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or ... min.
50	8	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Thomas B. Lawson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Catherine Lang

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Chas L. Watson (Address) 4014 Dorchester Road

15 Filed ... C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 28, 1929, to March 23, 1929, that I last saw h[illegible] alive on March 22, 1929, and that death occurred, on the date stated above, at 11.20 A m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. E. Jones M. D.

3/23, 1929 (Address) 720 N. Howard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemt DATE OF BURIAL March 26th 1929

20 UNDERTAKER Kettlewell & Fore ADDRESS 1723 W. Lafayette Ave

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1-PLACE OF DEATH **E 44363**

CERTIFICATE OF DEATH.

100-001 **E 44363**

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 13 1/2 W. Franklin ST. 17th WARD

2-FULL NAME Joseph Harry Gross

(a) RESIDENCE NO. 13 1/2 W. Franklin ST. ST., 17th WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 6 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 31, 1928

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	6	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — Man

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Joseph Gross

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto, Md.

12 MAIDEN NAME OF MOTHER Ruth Burley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Annapolis Md.

14 Informant Joseph Gross
(Address) 22 E. Franklin St.

15 Filed ... 19... G. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/22 19 29

17 I HEREBY CERTIFY, That I attended deceased from 3/17, 1929, to 3/22, 1929, that I last saw h[illegible] alive on 3/22, 1929, and that death occurred, on the date stated above, at 4.45 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema
Acute Dilatation

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Chemical + History

(Signed) W. H. Welch M. D.

, 19 (Address) 709 Hunt St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carvalry Mondawmin

DATE OF BURIAL Mar 24 1929

20 UNDERTAKER Mrs Katie R. Williams

ADDRESS 322 N. Schroeder St

Spec.—1-10-21—M&T—1500 Bks.

E 44364

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44364

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 628 (St.) Melville Ave (WARD) 9-47

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George H Buck

(a) RESIDENCE NO. 628 (St.) Melville Ave

(Usual place of abode)

WARD

Length of residence in city or town where death occurred 78 yrs. 5 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Harriet A Buck

6 DATE OF BIRTH (month, day, and year) Oct 7 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Leander W Buck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Margaret E Schilling

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mrs Harriet A Buck

(Address) 628 Melville Ave

15 Filed 3-24-1929 (19) HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb 28, 1929, to Mar 22 1929, that I last saw h alive on Mar 21 1929, and that death occurred, on the date stated above, at 7.5 p m.

The CAUSE OF DEATH* was as follows:

I Uremia

Chronic Nephritis (duration) yrs mos 4 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Ann B Lemmon, M. D.

3/24 1929 (Address) 718 N Pat Pkwy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery — DATE OF BURIAL Mar 25 1929

20 UNDERTAKER John F Denny — ADDRESS 715 Light St

IT IS very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 44365

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

29 E 44365

REGISTERED NO.

21-29

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 827 Woodward ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen Frances Bollman

(a) RESIDENCE NO. 827 Woodward ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 86 yrs. 5 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James H. Bollman

6 DATE OF BIRTH (month, day, and year) Oct 5 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	86	5	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) House-wife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Albert H. Bollman (Address) 827 Woodward St

15 Filed APR 24 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22nd 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 26, 1928, to March 22nd, 1929, that I last saw her alive on March 22nd, 1929, and that death occurred, on the date stated above, at 8-25 A m.

The CAUSE OF DEATH* was as follows:

(a) Chronic Interstitial Nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) (a) Acute Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Wood

(Signed) H. L. Cranmer, M. D.

March 24 1929 (Address) 1921 E Monument ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL Mar 25 19 29

20 UNDERTAKER John F. Denny — ADDRESS 715 Light St

FROM IS very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

223213

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44366

CERTIFICATE OF DEATH

69 ✓

E 44366

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 1667 WARD)

2—FULL NAME Virginia Robertson

(a) RESIDENCE NO. 3612 L - Lanvale ST. 18 - WARD
(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Ferguson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va -

12 MAIDEN NAME OF MOTHER Mary Binns

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va -

14 Informant Friends -

(Address) JOHNS HOPKINS HOSPITAL

Filed MAR 24 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March - 23 - 29

17 I HEREBY CERTIFY, That I attended deceased from March 8, 1929 to March 23, 1929

that I last saw her alive on March 23, 1929

and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Idiopathic Purpura Hemorrhagica

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) C. H. Bright, M. D.

3/24, 1929 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Richmond Va

DATE OF BURIAL March 25 1929

20 UNDERTAKER William G. Scheffer

ADDRESS 1806 Monument

Spec.—2-29-28—L. F. S.—500 Bks.

Dressel

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44367

CERTIFICATE OF DEATH

129

E 44367

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS [redacted] REGISTERED NO. 24-32

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

2—FULL NAME Henry Drissel

(a) RESIDENCE NO. 1009 Light ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. [illegible] mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): C40

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10 NAME OF FATHER: Conrad Drissel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Records of BALTIMORE CITY HOSPITALS (Address) [redacted]

15 Filed APR 24 1929 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 22, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 8, 1929, to March 22, 1929, that I last saw him alive on March 22, 1929, and that death occurred, on the date stated above, at 1:40 P m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension - uremia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) [illegible], M. D.

, 19 (Address) BALTIMORE CITY HOSPITALS [redacted]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cemetery	March 26, 1929
20 UNDERTAKER	ADDRESS
A. Howard Evans	138 E. Fort Ave

Spec.—2-29-28—L. F. S.—500 Bks.

E 44368 · 91-002 44368 · E 44368

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Camp Holabird ST. 26-36 (WARD)) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Bessie Cash

(a) RESIDENCE NO. 3138 9th Ave. ST. Long Island N. Y. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Benad Cash

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Capt. J. A. Mendelson

(Address) Camp Holabird, Md.

15 Filed C. HAMPSON JONES, M. D. Registrar

MAR 24 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 21, 1929, to March 23, 1929, that I last saw h er alive on March 23, 1929 and that death occurred, on the date stated above, at 12:50 P m.

The CAUSE OF DEATH* was as follows:

Coronary Occlusion

(duration) 5 hrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(duration) (?) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) W. N. Bispecel, M. D.

, 19 (Address) 132 W. Lombard St

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Long Island, N. Y.

DATE OF BURIAL Mch. 24 1929

20 UNDERTAKER Harry A. Watzke, 531 W. Lombard St.

ADDRESS

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44369

CERTIFICATE OF DEATH.

100-001

E 44369

REGISTERED NO.

1-PLACE OF DEATH.

CITY OF BALTIMORE: (No.) Sinai Hospital ST., 7-13 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William B. Wilkinson.

(a) RESIDENCE NO. Charleston W. Va ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Olive Wilkinson

6 DATE OF BIRTH (month, day, and year) 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Banker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pittsburg Pa

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant E. V. Brown

(Address) Charleston W. Va

Dec 25 1929 C. RAMSAY JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/22 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec. 15, 1928, to March 23 1929, that I last saw him alive on 3/22, 1929, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Cystic Kidney

Chronic Hydronephrosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchitis - Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 3/19/29.

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) L. E. Goodman, M. D.

3/23 1929 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Charleston W. Va

DATE OF BURIAL 3/24 1929

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E Balto

Spec.—1-10-21 M&T 1500 Bks.

E 44370

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 44370

1-PLACE OF DEATH Howard A. Kelly Hospital

CITY OF BALTIMORE: (No.) 1418 Eutaw Place (St.) (Ward) 20

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barrington Heath

(a) RESIDENCE NO. ..... Cartersville Ga. WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 13 1913

7 AGE			
16 Years	0 Months	8 Days	If LESS than 1 day, ... hrs or ..... min.
		11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School boy.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cartersville Ga

PARENTS

10 NAME OF FATHER Alfred Taylor Heath

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cartersville Ga

12 MAIDEN NAME OF MOTHER Annie Berley Howell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Atlanta Ga.

14 Informant Mr. A. H. Heath

(Address) Sumter S.C.

15 Filed MAR 25 1929, 19 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 27 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 27th, 1929, to Mar 27, 1929.

that I last saw him alive on Mar 27, 1929

and that death occurred, on the date stated above, at 3.20 P. m.

The CAUSE OF DEATH* was as follows:

Sarcoma of lymphatic glands

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Georgia

Did an operation precede death? yes Date of Jan 15 '29

Was there an autopsy? No.

What test confirmed diagnosis? Pathological examination

(Signed) Edmund Kelly M. D.

Mar. 19 (Address) 1406 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sumter South Carolina DATE OF BURIAL 3/24/29

20 UNDERTAKER Chas. G. Black ADDRESS 742 W. Fourth Ave

(Instructions on back of certificate. It is very important. See instructions.)

Cor.—10-10-29—A Co.—100 Blks.

E 44371

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

177

E 44371

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Hopkins Hospital St., 2-4 Ward)

2-FULL NAME Estela Pieniewski

(a) **RESIDENCE NO.** 2026 E. Pratt St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 26/1927

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	1	6	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Joseph Pieniewski

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland

12 MAIDEN NAME OF MOTHER Sophia Chielewski

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland

14 Informant Mother
(Address) 2026 E. Pratt St

15 Filed ... 19.. G. RAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 22/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Sodium Arsenite Poisoning
(Accidental)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? History

(Signed) [signature] M. D.

3/23/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary

DATE OF BURIAL March 25 19 29

20 UNDERTAKER F Wozazewski

ADDRESS 1934 Eastern Ave

important. See instructions on back of certificate.

23 1929

Spec.—2-29-28—L. F. S.—500 Blks.

Dr Rutledge – 1623 E Fort Ave ✓

E 44372 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

E 44372

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1912 Talbrook Ave ST., 15-37 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James A Thrash

(a) RESIDENCE NO. 1912 Talbrook Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Mar'd

a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Ella

6 DATE OF BIRTH (month, day, and year) July 4, 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	8	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steam Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) Ry. 045

(c) Name of employer Ry.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER James A Thrash

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Margaret Nail

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Margaret Innis

(Address) 1912 Talbrook Ave

15 MAR 25 1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23. 1929

17 I HEREBY CERTIFY, That I attended deceased from December 23, 1929, to March 22, 1929, that I last saw h alive on March 22, 19 and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

Bronchopneumonia

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Heart Failure & Arteriosclerosis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) Thos A Rutledge, M. D.

, 19 (Address) 1623 E Fort Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL 3/25 19 29

20 UNDERTAKER W. H. Cook

ADDRESS 1217 E Fort Ave

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44373

CERTIFICATE OF DEATH

57 E 44373

1—PLACE OF DEATH Provident Hospt.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1514 Division ST. 15-21 WARD)

2—FULL NAME Margaret Johnson

(a) RESIDENCE NO. 1715 Westwood Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Colored	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	45	—	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 0/0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Richmond Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Self

(Address)

15 Filed MAR 25 1929 L. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1929, to March 23, 1929

that I last saw her alive on March 23, 1929

and that death occurred, on the date stated above, at 4 10 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Blood & Urine Chem

(Signed) C. Jackson M. D.

3/24/29 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	3-25 1929
20 UNDERTAKER	ADDRESS
Dennis Easton	916 Park Ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

44374

CERTIFICATE OF DEATH

E 44374

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 734 Bradley Av St.) (Ward) 17-26

2-FULL NAME Louis Gidley

(a) RESIDENCE NO. 734 Bradley Av St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1853

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	76	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Grace Tilles
(Address) 734 E Franklin St

Filed MAR 25 1929 HAMPSON JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22nd 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an
(Inquest, autopsy or inquiry)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
(duration) 2 yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) March 22nd 1929 M. D.
(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem

DATE OF BURIAL 3-25-1929

20 UNDERTAKER D Daniel Easton

ADDRESS 916 Ca ave

important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 1 ks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 44375

1-PLACE OF DEATH

90

E 44375

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of Baltimore: (No. 1322 N. Stockton St. 15-23 Ward)

2-FULL NAME Mamie Mary E Clifford-Moody.

(a) RESIDENCE NO 1322 N. Stockton St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm E. Clifford

6 DATE OF BIRTH (month, day, and year): 1871

7 AGE: Years 58 | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country): Md.

PARENTS

10 NAME OF FATHER: Don't know

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Don't know

12 MAIDEN NAME OF MOTHER: Don't know

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Don't know

14 Informant: Wm E. Clifford
(Address) 1322 N. Stockton St

15 [illegible] 25 1929 C. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 23rd 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regulars

(Signed) [illegible] M. D.

March 24th (Address) Corners

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Olivet Cem

DATE OF BURIAL: 3-26 1929

20 UNDERTAKER: Wm H Eaton

ADDRESS 916 Ba ave

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—600 Bks.

Wohnka

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44376

CERTIFICATE OF DEATH

E 44376

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 10 Balt Gen Hosp ST. WARD)

2—FULL NAME Frank Jr. Wohnka

(a) RESIDENCE NO. 3019 E. White Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Wh.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emma R. Wohnka

6 DATE OF BIRTH (month, day, and year): Jan 10, 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	46	2	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Engineer on F.30

(b) General nature of industry, business, or establishment in which employed (or employer): Fire Boat.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: John Wohnka

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs J. J. Wohnka

(Address) 3519 White Ave

15 Filed ... 25 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 23 1929

17 I HEREBY CERTIFY, That I attended deceased from Mar 17, 1929, to Mar 23, 1929

that I last saw h... alive on Mar 23, 1929

and that death occurred, on the date stated above, at 7 35 a. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. 4 ds. ?

CONTRIBUTORY (Secondary) Carcinoma of Stomach

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Mar 19, 1929

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) William H. Chew, M. D.

, 19 (Address) 10 Balt Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: Mar 26 29

20 UNDERTAKER: Fred A. Wanser & Co. — ADDRESS: 703 Hamilton

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

118-002

E 44377

CERTIFICATE OF DEATH

E 44377.

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1920 Sherwood ST. 9-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Betty Alice Dix Holmes.

(a) RESIDENCE NO. 1920 Sherwood ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 ~~Single~~, ~~Married~~, Widowed, ~~or Divorced~~, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Late Jacob Holmes.

6 DATE OF BIRTH (month, day, and year): Dec. 25 1861

7 AGE: Years 67 | Months 2 | Days 28 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: John Kelly.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland.

14 Informant: Charles Dix Son.

(Address) 1920 Sherwood ave.

15 Filed: MAR 25 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/23/29

17 I HEREBY CERTIFY, That I attended deceased from March 20, 1929, to March 24, 1929, that I last saw her alive on March 23, 1929, and that death occurred, on the date stated above, at 4.15 P.M.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary): Arthritis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. C. Jones, M. D.

(Address) 1501 E. Eager March 24, 1929

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary Cemty. Hampden.	March. 26 1929
20 UNDERTAKER	ADDRESS
Sprenger & Rust.	1735 Harford av

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44378 129 ✓ **E 44378**

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1501 Webster st ST. 24-34 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John M. Wilson

(a) RESIDENCE NO. 1501 Webster St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Estella Wilson

6 DATE OF BIRTH (month, day, and year) July 18 1861

7 AGE	Years	Months	Days 3	If LESS than 1 day, ...hrs. or ...min.
	67	8	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired R

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford Co. Md.

PARENTS

10 NAME OF FATHER Robt. L. Wilson

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Sarah Taylor

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Mrs. John M. Wilson
(Address) 1501 Webster St

15 Filed MAR 25 1929 C. HARRISON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3. 21. 29.

17 I HEREBY CERTIFY, That I attended deceased from 9. 27, 1928, to 3. 21. 29, 19..., that I last saw h... alive on 3. 21. 29, 19..., and that death occurred, on the date stated above, at 9.30 m.

The CAUSE OF DEATH* was as follows:

(a) Chronic Endocarditis

(duration) ... yrs. 1 mos. ... ds.

CONTRIBUTORY (Secondary) Chronic Parenchymatous nephritis

(duration) 2 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical-chemical-microscopic

(Signed) Philip B. Taylor, M. D.

3.25.29 19 (Address) 1432 William st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL 3/25 1929

20 UNDERTAKER J. Few McCully

ADDRESS 130 E. Fort

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44379

CERTIFICATE OF DEATH.

E 44379

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1041 Mount ST. (WARD)

2-FULL NAME James Grier

(a) RESIDENCE NO. 1041 Mount ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie Grier

6 DATE OF BIRTH (month, day, and year) Sept 12, 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	6	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Charlotte N C.

PARENTS

10 NAME OF FATHER Isaac Grier

11 BIRTHPLACE OF FATHER (city or town) (State or country) N C.

12 MAIDEN NAME OF MOTHER Susana De Bose

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Charlotte N C.

14 Informant Jennie Grier (Address) 1041 Mount St

15 Filed MAR 25 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 23 1929

17 I HEREBY CERTIFY, That I attended deceased from Mar 17, 1929, to Mar 23, 1929, that I last saw h[illegible] alive on Mar 22, 1929, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E William Frey M. D.

3/23, 1929 (Address) 928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL W. Grove — DATE OF BURIAL Mch 26 29

20 UNDERTAKER Smith & Crase — ADDRESS [illegible]

FRONT is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 44380 ✓ E 44380

179

REGISTERED NO. 7-13

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1037 N. Durham ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Parthinia Roberts

(a) RESIDENCE NO. 1037 N. Durham ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Col

5 Single, ~~Married~~, Widowed, or ~~Divorced~~, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Hubbard Roberts

6 DATE OF BIRTH (month, day, and year): Apr 25 51

7 AGE: Years 77 | Months 10 | Days 27 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer: 0

9 BIRTHPLACE (city or town) (State or country): Brunswick Co Va

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country):

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Etha Scott

(Address) Roanoke Va.

15 Filed MAR 25 29 J. HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 22. 1929

17 I HEREBY CERTIFY, That I attended deceased from March 15 1929 to March 22 1929

that I last saw h alive on March 21 1929

and that death occurred, on the date stated above, at 7.4 m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. 7 mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Urinary

(Signed) [illegible], M. D.

3/23. 1929 (Address) 1126 Druid Hill

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: W. Laurel — DATE OF BURIAL: Mch 25 1929

20 UNDERTAKER: Wm. H. Crane Son — ADDRESS: 1400 Mosher

Spec.—2-29-28—L. F. S.—500 Bks.

Dr Norwood 931 W. Fayette St

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44381

CERTIFICATE OF DEATH

124

REGISTERED NO. **E 44381**

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1421 W. Balto ST. 14-28 (WARD)

2—FULL NAME Ida Nurnburger

(a) RESIDENCE NO. 1421 W. Balto ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 15th 1865

7 AGE — Years: 63 — Months: 9 — Days: 9 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Gustav Nurnburger

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Wilhelmina Hess

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs. Ida Nurnburger
(Address) 1421 W. Balto St

15 Filed MAR 25 1929 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24/29

17 I HEREBY CERTIFY, That I attended deceased from March 17, 1929, to March 24, 1929,

that I last saw h alive on March 23 1929

and that death occurred, on the date stated above, at 8.45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial

CONTRIBUTORY (Secondary) Pulmonary Oedema (duration) Unknown yrs. mos. ds.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) H. Norwood M. D.

March 25, 1929 (Address) 931 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	March 26th 1929
20 UNDERTAKER	ADDRESS
F. D. Klapfert	1850 W. Balto St

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44382 90 **E 44382**

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2307 Belair Road St. 8-40 Ward)

2-FULL NAME Helen M. Thompson

(a) RESIDENCE NO. 2307 Belair Road St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nellen Law Thompson

6 DATE OF BIRTH (month, day, and year) Sept 12 1853

7 AGE	Years	Months	Days	If LESS than 1 day ....hrs. or ....min.
	75	6	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer 0

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER Henry Moran

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Sophia Graham

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Mamie E. Pennyan

(Address) 2307 Belair Rd

15 Filed MAR 25 1929 HAMPSON JONES, M. D., Registrar

By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 24 1929

17 I HEREBY CERTIFY, That I attended deceased from March 1928, to March 24, 1929, that I last saw her alive on March 23, 1929, and that death occurred, on the date stated above, at 12.10 P m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ✓ yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Lab.

(Signed) Isidor Fry, M. D.

March 19 29 (Address) 2324 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Morganza Md. Date of Burial Mar 25 1929

20 UNDERTAKER Grant Croxton ADDRESS 1906 Eutaw

very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—300 Blks.

Sonner

E 44383

HEALTH DEPARTMENT—CITY OF BALTIMORE

86-001 V

CERTIFICATE OF DEATH

E 44383

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. So Dallo Ave ST. 24-33 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

REGISTERED NO.

2—FULL NAME Baby Edward Sonner

(a) RESIDENCE NO. 1423 Covington ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 29, 1928

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		4	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work No Occupation

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Edward Sonner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sylvia Konakel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Edward Sonner

(Address) 1423 Covington

15 Filed MAR 25 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24-1929.

17 I HEREBY CERTIFY, That I attended deceased from March 22, 1929, to March 24, 1929, that I last saw h[illegible] alive on March 24 1929 and that death occurred, on the date stated above, at 2:30 a. m.

The CAUSE OF DEATH* was as follows:

Asphyxia Meningitis

Edward Sonner

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia Lobular Left Lung

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Not at hospital

What test confirmed diagnosis? Clinical Symptoms

(Signed) E. C. Lillingston, M. D.

3-24-, 1929 (Address) 1423 E. Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross — DATE OF BURIAL 3-26-1929

UNDERTAKER E. B. Harker — ADDRESS 115 E. Lanvale

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44384

CERTIFICATE OF DEATH

90

E 44384

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1625 Cliftview Ave. ST., 8-45 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emma Reid

(a) RESIDENCE NO. 1625 Cliftview Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Late James Reid

6 DATE OF BIRTH (month, day, and year) Jan. 8, 1863.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	2	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Lingelbach

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Johanna Brumming

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs. Margaret Lohmann

(Address) 2042 E. Federal St.

15 Filed APR 25 1929 O. HAMILTON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/22/29.

17 I HEREBY CERTIFY, That I attended deceased from 12/31/28 to 3/22/29

that I last saw her alive on 3/19/29

and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. 2 mos. 21 ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) Geo A Bowden, M. D.

3/23, 1929 (Address) 1517 E North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem.

DATE OF BURIAL Mch. 25 1929

20 UNDERTAKER Jas. A. Wilkes

ADDRESS 533 W. Lombard St

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44385

CERTIFICATE OF DEATH.

29 E 44385

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1517 (Street) Pennsylvania Ave 15-21 (Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Jas. Bean

(a) RESIDENCE NO. 1517 (Usual place of abode) Pennsylvania Ave Ward

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jas. Bean

6 DATE OF BIRTH (month, day, and year): Sept 28 1880

7 AGE: Years 48 Months 5 Days 4 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Washington

(State or country) D. C.

10 NAME OF FATHER: E E Edmonds

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Va.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Va

PARENTS

14 Informant: Mrs Hattie Roberts

(Address) 1517 Pennsylvania Ave

15 Filed MAR 25 1929 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/22/29

17

I HEREBY CERTIFY, That I attended deceased from Mar 17, 1929 to Mar 22, 1929, that I last saw h.. alive on Mar 22, 1929 and that death occurred, on the date stated above, at 8:40 a.m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. 2 mos. 7 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) John H. Tomlinson M. D.

3/23/29 (Address) 1012 N. Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery — Date of Burial: Mar 26 1929

20 UNDERTAKER: Thomas E. Kelson — ADDRESS 1303 Pennsylvania Ave

very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44386
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

112

E 44386

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of BALTIMORE: (No. 813 Aretta ave St. 25-10 Ward)

2-FULL NAME Ferdinand J. Bockelman

(a) RESIDENCE NO. 813 Aretta ave St._____ Ward_____
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Alice Bockelman

6 DATE OF BIRTH (month, day, and year): Apr 4th 1887

7 AGE — Years: 42 — Months: 11 — Days: 27 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Salesman
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore
(State or country)

PARENTS

10 NAME OF FATHER: George A. Bockelman

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Emma K. Arndt

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Baltimore

14 Informant: Dora E. Bockelman
(Address): 2527 Arunah ave

15 Filed.....19.....
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mch 22 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) Chas. H. Grove M. D.
(Coroner)

3/24 1927 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: London Park — Date of Burial: March 25 1927

20 UNDERTAKER: Eschlman & Son — ADDRESS 1029 Hanover St.

very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44387

CERTIFICATE OF DEATH.

154-002

E 44387.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital ST. 913 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Le Schack.

(a) RESIDENCE NO. Sinai Hospital ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 19 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Abraham Le Schack

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Matilda Light

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York.

14 Informant Abraham Le Schack

(Address) Forest Park Balto

15 Filed 19 RAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/25 1924

17 I HEREBY CERTIFY, That I attended deceased from 3/19 1924 to 3/25 1924

that I last saw her alive on 3/25 1924

and that death occurred, on the date stated above, at 8.10 P m.

The CAUSE OF DEATH* was as follows:

Congenital Heart

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Atelectasis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of no.

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) H. E. Goodman M. D.

19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Hebrew Cem. DATE OF BURIAL 3/25 1924

20 UNDERTAKER Harris Sondheim ADDRESS 1118-20 W. Pratt Royal Ave

Spec.—2-29-28—L. F. S.—500 Bks.

E 44388

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001

E 44388

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Forest Hill Cem. 5-6 WARD) 23-10

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Gabriel Pollock

(a) RESIDENCE NO. Forest Hill Cem. WARD 23-10

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE Bertha H. Pollock

6 DATE OF BIRTH (month, day, and year) May. 12, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	10	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Kohn & Pollock

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Philadelphia Pa.

PARENTS

10 NAME OF FATHER —— Pollock

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Julia ——

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Julian Pollock

(Address) Forest Hill Cem.

15 Filed ....., 19.... HAMPSON ..... Registrar

MAR 25 1928

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24, 1928

17 I HEREBY CERTIFY, That I attended deceased from March 22, 1928 to March 24, 1928, that I last saw him alive on March 23, 1928 and that death occurred, on the date stated above, at 1:17 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at his place of business

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? none

(Signed) Louis E. Mayer, M. D.

3/27, 1928 (Address) The Esplanade

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Hebrew Cem.	3/24 1928
20 UNDERTAKER David Sondheim	ADDRESS 815-20 W. Mt. Royal Ave.

Spec.—2-29-28—L. F. S.—600 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44389

CERTIFICATE OF DEATH

REGISTERED NO. E 44389

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Esplanade Apts. (St.) 13-5 (WARD) 49

2—FULL NAME Louis Kahn

(a) RESIDENCE NO. Esplanade Apt. (St.) WARD

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 23, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	63	4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Samuel Kahn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Fannie Steiner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant A. Mueller

(Address) Esplanade Apts.

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 15, 1928, to March 24, 1929, that I last saw h. alive on March 24, 1929, and that death occurred, on the date stated above, at 7.10 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Lungs

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? usual

(Signed) Erwin E. Mayer, M. D.

3/25, 1929 (Address) The Esplanade

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Adel Shalom Cem	3/26/1929

20 UNDERTAKER Heard Sondheim ADDRESS 1720 W. Mt. Royal Ave

Spec.—1-10-21—M&T—1500 Bks.

E 44390 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 44390 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 710 Washington Blvd (Street) 21-29 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Gundlach

(a) RESIDENCE NO. 710 Washington Blvd (Usual place of abode) WARD

Length of residence in city or town where death occurred 72 yrs. 8 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	M

5a If married, widowed, or divorced HUSBAND of or) WIFE of Louis Gundlach

6 DATE OF BIRTH (month, day, and year) Feb 24 58

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
71 72	0	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoe Store

(b) General nature of industry, business, or establishment in which employed (or employer) Owner

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Henry Erbe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER E. Crist

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Louis Gundlach (Address) 710 Washington Blvd.

15 MAR 25 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23 1929

17 I HEREBY CERTIFY, That I attended deceased from Mar 20th 1929 to Mar 23rd 1929, that I last saw h. alive on Mar 23rd 1929, and that death occurred, on the date stated above, at 7.30P m.

The CAUSE OF DEATH* was as follows:

Heart Failure Exhaustion

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F E Poulton M. D.

3/26, 1929 (Address) 3901 Gamon Blvd,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem DATE OF BURIAL Mar 26 1929

20 UNDERTAKER W M Poulton ADDRESS 2238 N Howard

TION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Dr Forsyth ✓ Frederick 90

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 44391

1—PLACE OF DEATH

REGISTERED NO. **E 44391**

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 3013 N. North Ave ST. (WARD) 15-67

2—FULL NAME Charles G. Batchelor

(a) RESIDENCE NO. 3013 N. North Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary F. Batchelor

6 DATE OF BIRTH (month, day, and year): May 9, 1860

7 AGE: Years 68 | Months 10 | Days 4 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Louis G. Batchelor

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Maria Stewart

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Mary F. Batchelor
(Address): 3013 N. North Ave

15 MAR 25 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 23. 1929

17 I HEREBY CERTIFY, That I attended deceased from March 22, 1929, to March 23, 1929, that I last saw h(e) alive on March 22, 1929 and that death occurred, on the date stated above, at 1 1 P m.

The CAUSE OF DEATH* was as follows:

a. Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? No.

(Signed) Royal Forsythe, M. D.

3 25, 1929 (Address) 422 E North ave,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Union Cem

DATE OF BURIAL: 3 26 1929

20 UNDERTAKER: H. C. Cook

ADDRESS: 2122 Pres St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44392

CERTIFICATE OF DEATH

146 V

E 44392
REGISTERED NO.

1-PLACE OF DEATH

City of Baltimore: (No. Hopkins Hospital St., 9-46 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Irma Davis

(a) RESIDENCE NO. 924 Montpelier St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 6 mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
female male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 4/1902

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	26	8	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer U.S.F. & G. Co

9 BIRTHPLACE (city or town)
(State or country) Md.

PARENTS

10 NAME OF FATHER John Davis

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Henrietta Campbell

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Mrs. Ella F. Fletcher
(Address) 924 Montpelier St

15 Filed ....., 19..... Registrar

APR 5 1929 HAMPSON (CORP.), INC.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24/1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Puerpal Peritonitis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Self induced abortion

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Report of deceased

(Signed) John Allen, M. D.

3/25/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sillville Md

DATE OF BURIAL 3/25 1929

20 UNDERTAKER William Cook

ADDRESS 1217 Druid

important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 44393

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 **E 44393**

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 129 W. Hamburg St. St. 23rd Ward)

2-FULL NAME John McCullough.(C)

(a) RESIDENCE NO. 129 W. Hamburg St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. ------ (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Widower.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Do not know.

6 DATE OF BIRTH (month, day, and year): March 18, 1880

7 AGE	Years	Months	Days	LESS than 1 day.....hrs. or.....min.
	49	0	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer): Do not know.

(c) Name of employer: Do not know.

9 BIRTHPLACE (City or town)

(State or country): South Carolina.

PARENTS

10 NAME OF FATHER: Do not know.

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Do not know.

12 MAIDEN NAME OF MOTHER: Sarah Jackson.(C)

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): South Carolina.

14 Informant: Sally McCullough.(C) daughter

(Address): 605 W. Conway St.

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

MAR 25 1926 By: .....

very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 22, 1926

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute dilatation of the Heart.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

(Coroner)

3/28, 19 29 (Address) 1017 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Zion Date of Burial: March 25 19 29

20 UNDERTAKER: J. L. Bloom ADDRESS: 1601 Pennsylvania Ave

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44394 — 46 E 44394

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 809 Sharp ST. 22 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Laura Blake

(a) RESIDENCE No. 809 Sharp ST., 22 WARD
(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 8, 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	46	2	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ... 0

(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER William H. Blake

11 BIRTHPLACE OF FATHER (city or town) Chester (State or country) Town, Md.

12 MAIDEN NAME OF MOTHER Susie F. Ward

13 BIRTHPLACE OF MOTHER (city or town) Eastern Shore (State or country) Somerset Co. Md.

14 Informant ... (Address) 1526 Bloom St

15 Filed APR 25 1929 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/22/1929

17 I HEREBY CERTIFY, That I attended deceased from 2/21, 1929, to 3/22, 1929, that I last saw her alive on 3/22, 1929 and that death occurred, on the date stated above, at 5.20 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation
Angina Pectoris

(duration) yrs. 1 mos 1 ds.

CONTRIBUTORY (Secondary) Carcinoma of Ovary (duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? yes Date of Jan 1929

Was there an autopsy? No

What test confirmed diagnosis? Physical & History

(Signed) ... M. D.

, 19 (Address) 709 Sharp St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn mar 26 1929 — DATE OF BURIAL

UNDERTAKER ... ADDRESS Bowerson Building

Cor.—10-10-29—A Co.—100 Bks.

E 44395

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 44395

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 936 Boyd St., 18-76 Ward)

2-FULL NAME Charles Warren

(a) RESIDENCE NO. 936 Boyd St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Negro	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice Warren

6 DATE OF BIRTH (month, day, and year) April 27-1878

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	50	10	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER Gassaway Warren

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Lillie R. Bennett
(Address) 32 N. Bruce St

15 Filed MAR 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Feller, M. D.

March 25 19 29 (Address) 2732 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	March 25 1929
20 UNDERTAKER	ADDRESS 322
Mrs. Katie R. Williams	N Schroeder St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44396

CERTIFICATE OF DEATH.

38 **E 44396**

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 307 N. Central Ave Ward 8)

2-FULL NAME Hattie Jefferson

(a) RESIDENCE NO. 307 N. Centralave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 Color or Race: C.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eligah Jefferson

6 DATE OF BIRTH (month, day, and year) Unknown, 1885

7 AGE: Years 44 Months Days IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 0'10

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown.

14 Informant Albert H. Jefferson (Address) 307 N. Central Ave

15 Filed ....., 19 .....

C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch 24/29

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intracranial Hemorrhage.
Rupture of Cerebeller Aneurism
(Autopsy at Hopkins)

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

(duration) ....yrs. ....mos. ....ds.

(Signed) J. M. Watkins, M. D. (Coroner)

3/25/29 (Address) 509 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Date of Burial: Mar. 27 29

20 UNDERTAKER: Mrs. R. G. Elliott ADDRESS 1125 Eastlan[illegible]

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 44397

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

148 E 44397

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. John Hopkins Hosp. Ward) 9

2-FULL NAME Cardenus Johnson

(a) RESIDENCE NO. 1609 McElderry St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	C.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 29, 1893

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	36	1	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer) J. H. Hospital

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.

(State or country) Md.

PARENTS

10 NAME OF FATHER George W. Johnson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Josephine Jones

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Richard C. Johnson

(Address) 1609 McElderry St

AMPSON JONES, M.D.

3/21/29

C. HAMPSON JONES, M.D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 20-29

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Stab wound of chest involving lung & heart (Homicide)

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) J. H. Cain M. D.
(Coroner)

3/20/29 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary Date of Burial Mar 23 29

UNDERTAKER Wm. P. G. Elliott Mgr ADDRESS 5 E. Baltimore

very important. See instructions on back of certificate. PART STATEMENT OF OCCUPATION IS

Spec.—2-29-28—L. F. S.—500 Bks.

E 44398 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001

E 44398

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1730 E. Oliver ST.) (8-17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lucretia E. Lamb

(a) RESIDENCE NO. 1730 E. Oliver ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married~~, Widowed, ~~or Divorced~~ (Write the word): widowed

5a If ~~married, widowed, or divorced~~ ~~HUSBAND~~ of (or) WIFE of: Joseph Lamb

6 DATE OF BIRTH (month, day, and year): March 28, 1843

7 AGE: 85 86 Years | 11 Months | Days 24 | If LESS than 1 day, ___ hrs. or ___ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md

PARENTS

10 NAME OF FATHER: Charles Sherman

11 BIRTHPLACE OF FATHER (City or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Elizabeth

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Baltimore, Md

14 Informant: Mary E. McCone

(Address): 33 E. Oliver St

15 Filed MAR 25 1929 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 23, 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1929, to March 23, 1929

that I last saw her alive on March 9, 1929

and that death occurred, on the date stated above, at 11.30 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Symptoms

(Signed) Geo. H. Lee, M. D.

3-25-29 (Address) 1937 Gough

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Co.

DATE OF BURIAL: March 1929

20 UNDERTAKER: Robert J. Turner

ADDRESS: N. Avenue

Spec.—12-9-25—A Co.—200 Bks.

E 44399

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-08

E 44399

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1218 N Potomac St. (Ward)

2-FULL NAME John allen Hudson Jr

(a) RESIDENCE NO. 1218 N Potomac St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or ~~Divorced~~, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jany 3. 1929

7 AGE — Years: — Months: 2 Days: 4 If LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

10 NAME OF FATHER John T Hudson

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Baltimore

12 MAIDEN NAME OF MOTHER Bruce A Bradley

13 BIRTHPLACE OF MOTHER (City or town)

(State or country) Maryland

PARENTS

14 Informant John T Hudson Sr

(Address) 1218 N Potomac St

Filed MAR 25 1929

C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-27 1929

17

I HEREBY CERTIFY, That I attended deceased from March 23 1929, to March 27, 1929, that I last saw him alive on March 23, 1929, and that death occurred, on the date stated above, at 1.20 A m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Fred L Zimmerman, M. D.

3-27, 1929 (Address) 1935 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury; and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Date of Burial Mch 28 1929

20 UNDERTAKER Robt Kinner & Bro ADDRESS

very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Hanley

E 44400 HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 44400

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mt Hope Retreat ST. 28-63 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sarah Hanley

(a) RESIDENCE NO. Mt Hope Retreat ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 10 mos. 24 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 19, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	10	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Michael Hanley

11 BIRTHPLACE OF FATHER (city or town) — (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Ward

13 BIRTHPLACE OF MOTHER (city or town) — (State or country) Ireland

14 Informant Mt Hope Friends

(Address) Mt Hope Retreat

15 Filed 25 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24. 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1928, to March 24, 1929, that I last saw h[illegible] alive on March 24, 1929 and that death occurred, on the date stated above, at 11.10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(Valvular Insufficiency)

Unknown (duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Dementia

(duration) 40 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Jungle

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Milton P. Bell, M. D.

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Wesley Methodist Cemetery	Mar 29 29
UNDERTAKER	ADDRESS
Howard Woods	Balto

Spec.—2-29-28—L. F. S.—500 Bks.

E 44401

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 44401

1—PLACE OF DEATH Union Memorial Hosp. REGISTERED NO.

CITY OF BALTIMORE: (No. 32 d + Calvert ST., 12-24 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frances Capogrosso

(a) RESIDENCE NO. 715 Merchant St ST., West WARD Fairmont W. Va.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 1 mos. 9 ds. How long in U. S., if foreign birth? 2 yrs. 3 mos. 19 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W	S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Del 3/26 (Single)

6 DATE OF BIRTH (month, day, and year) ~~Dec 3/26~~ 3/26

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	2	3	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Fairmont (State or country) West Va.

PARENTS

10 NAME OF FATHER Frank A. Capogrosso

11 BIRTHPLACE OF FATHER (city or town) St George (State or country) Italy

12 MAIDEN NAME OF MOTHER Mary Larosa

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Va

14 Informant Mother

(Address) Fairmont W. Va.

15 Filed 5-1-1929, 19 C. HAMPSON JONES, M. D. Registrar

Par

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/24/29

17 I HEREBY CERTIFY, That I attended deceased from 2/15, 1929, to 3/24, 1929 that I last saw h[illegible] alive on 3/24, 1929 and that death occurred, on the date stated above, at 10.05 A.m.

The CAUSE OF DEATH* was as follows:

Cerebellar Cyst

(duration) 1 yrs. 6 mos. X ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of 2/25/29

Was there an autopsy?

What test confirmed diagnosis? Operation

(Signed) W. K. Swartzwelder, M. D.

19 (Address) Union Memorial Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Fairmont W. Va.	Mar 26/29.
20 UNDERTAKER Elwood Monroe	ADDRESS Falls

Spec.—2-29-28—L. F. S.—500 Bks.

E 44402

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

73

E 44402

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3100 Brighton ST. 16-67 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Adella Sheddan

(a) RESIDENCE NO. 3100 Brighton ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. B. Sheddan

6 DATE OF BIRTH (month, day, and year) April 5-1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
62	61	11	20 (8)	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) California

PARENTS

10 NAME OF FATHER Oliver Shakespeare

11 BIRTHPLACE OF FATHER (city or town) (State or country) Un known

12 MAIDEN NAME OF MOTHER Eva Greenlee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Lloyd Sheddan

(Address) 3100 N. Monroe

15 Filed MAR 25 1929 19 JAMES H. JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23-29

17

I HEREBY CERTIFY, That I attended deceased from March 8, 19 29, to March 23 19 29, that I last saw h[illegible] alive on March 21, 19 29 and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Progressive Ataxia Cerebellar (Tendency to Bronchitis)

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John H. Evans M. D.

19 (Address) 612 W. 40th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	3/25 19 29

20 UNDERTAKER William Cook ADDRESS 919 N. Paul

Spec.—2-29-28—L. F. S.—500 Bks.

E 44403 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. **E 44403**

1—PLACE OF DEATH Provident Hospl. 129 ~ 16-22

CITY OF BALTIMORE: (No. 1514 Division ST. 16-22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rachel Smith

(a) RESIDENCE NO. 1122 Calhoun ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
F	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	42	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt. Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

11 Informant Self

(Address) 1122 N. Calhoun St

11 Filed MAR 25 1929 HAMPSON JONES, M. D. Registrar

Dat

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 22, 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb 26, 1929, to March 22 1929 that I last saw h er alive on March 22, 1929 and that death occurred, on the date stated above, at 2 p m.

The CAUSE OF DEATH was as follows:

Chr Nephritis

(duration) Undetermined yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 18 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Minimal Blood Chem

(Signed) [illegible] Jackson, M. D.

3/22/29 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Lebanon Cemetery DATE OF BURIAL Mar 26 1929

20 UNDERTAKER Virginia A Booth ADDRESS 1463 N Carey

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 44404

CERTIFICATE OF DEATH

REGISTERED NO. E 44404

1—PLACE OF DEATH Memorial Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 33rd ST. 13-27 WARD)

2—FULL NAME Mr Eli Sheffer

(a) RESIDENCE NO. 3347 Keswick Rd ST., 13 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Eli Sheffer

6 DATE OF BIRTH (month, day, and year) Nov. 27-1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	3	25	

8 OCCUPATION OF DEACESED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) R 015

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penna.

PARENTS

10 NAME OF FATHER Jacob Sheffer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn

12 MAIDEN NAME OF MOTHER Mary Bailey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn

14 Informant Hospital Records

(Address)

15 Filed APR 25 1929 C. HAMILTON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/24/29

17

I HEREBY CERTIFY, That I attended deceased from March 20th, 19 29, to March 24th 19 29,

that I last saw h. in alive on March 23rd, 19 29

and that death occurred, on the date stated above, at 4.20 a. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia Lobar Extended

(duration) 0 yrs. 0 mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Findings

(Signed) Calvin G. C. Williams, M. D.

, 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	March 27 1929.
UNDERTAKER Horace H. Burgee	ADDRESS 3621 Falls Road

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 44405 — **CERTIFICATE OF DEATH** — **E 44405**

REGISTERED NO. .....

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 133 N. Hare ST. 6-11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Norman D. Long

(a) RESIDENCE NO. 133 N. Hare ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	M

.a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie R. Hefel

6 DATE OF BIRTH (month, day, and year) Dec 13-1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	55	3	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 066

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Wm. Long

11 BIRTHPLACE OF FATHER (city or town) Balto City (State or country)

12 MAIDEN NAME OF MOTHER Arnold Ruley

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Mrs Carrie Long

(Address) 133 N. Hare St.

Rec'd MAR 25 1929 Reg. No. ..... 19 .....

HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23, 1929

17 I HEREBY CERTIFY, That I attended deceased from Mar 12, 19 29, to Mar 23, 19 29,

that I last saw him alive on Mar 22, 19 29,

and that death occurred, on the date stated above, at 2 [illegible] m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. 11 ds.

CONTRIBUTORY (Secondary) .....

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? dwelling

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? clinic

(Signed) J. Knox Insley, M. D.

, 19 29, (Address) 2038 Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL March 26 19 29

20 UNDERTAKER John J. Moran. — ADDRESS 3000 E. Balto

Spec.—2-29-28—L. F. S.—500 Bks.

E 44406 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129

E 44406

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 31 W. Potomac ST., 6-11 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Goetz

(a) RESIDENCE NO. 31 W. Potomac ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F | 4 COLOR OR RACE W | 5 Single, Married, Widowed, or Divorced, (write the word) Widow

a If married, widowed, or divorced HUSBAND of (or) WIFE of Daniel Goetz

6 DATE OF BIRTH (month, day, and year) Jan 1-1857

7 AGE Years 72 | Months 2 | Days 23 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer 0

9 BIRTHPLACE (city or town) (State or country) Ireland

10 NAME OF FATHER Michael Linton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

PARENTS

14 Informant Mrs L. Goetz

(Address) 31 W. Potomac

Filed MAR 25 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23, 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 28, to March 23, 29, that I last saw her alive on March 22, 19 and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Don't know.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. Hampson Jones, M. D.

March 25, 1929 (Address) 2938 Saint Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross | DATE OF BURIAL March 27, 1929

20 UNDERTAKER John A. Moran | ADDRESS 3000 E. Baltimore

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44407 — CERTIFICATE OF DEATH — E 44407

1—PLACE OF DEATH: University Hospital — REGISTERED NO. 4-36

CITY OF BALTIMORE: (No. ... ST. ... WARD) — (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME: William Langschmidt

(a) RESIDENCE NO. Hazel Ave. ST. ... WARD ... Relay, Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 7 ds. How long in U. S., if foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR [redacted]

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sophia Langschmidt

6 DATE OF BIRTH (month, day, and year): April 13 1858

7 AGE: Years 70 | Months 11 | Days 12 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Pfalts Md

PARENTS

10 NAME OF FATHER: Wm. Langschmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Henriette Schroder

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Edw Langschmidt
(Address): Hazel Ave Relay

15 Filed ... 19 ... C. HAMPSON JONES, M. D. Registrar

2 5 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 25, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 18, 1929, to March 25, 1929.
that I last saw h[redacted] alive on March 25, 1929
and that death occurred, on the date stated above, at 10:45 A m.

The CAUSE OF DEATH* was as follows:
Volvulus of Colcum
rupture of colcum.

... (duration) ... yrs. 1 mos. ... ds.

CONTRIBUTORY (Secondary): Peritonitis + pneumo-peritoneum (duration) ... yrs. 1 mos. ... ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? Yes Date of March 18, 1929

Was there an autopsy? yes Gunston

What test confirmed diagnosis? Physical Examination

(Signed) ... M. D.

... 19 (Address) University Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Pauls (Violetsville)	3-27-1929
20 UNDERTAKER: Mrs Chas A Roth	ADDRESS: 2347 Edmondson Ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 44408

1-PLACE OF DEATH

City of Baltimore: (No. W. Balto Gen Hosp 27-56 Ward)

2-FULL NAME Rachel E Richmond

(a) RESIDENCE NO. 5021 Parkhurst Ward

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. 10 mos. 26 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

E 44408

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Fmale	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jas M Richmond

6 DATE OF BIRTH (month, day, and year) May 30 1868

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	60	10	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House-wife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto md
(State or country)

PARENTS

10 NAME OF FATHER Wm Malone

11 BIRTHPLACE OF FATHER (city or town) md.
(State or country)

12 MAIDEN NAME OF MOTHER Hannah Emick

13 BIRTHPLACE OF MOTHER (city or town) md.
(State or country)

14 Informant Jas Richmond
(Address) 5021 Parkhurst

Filed MAR 25 1929 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

3rd degree burns over body; (duration) yrs. mos. one hrs.
Clothing caught fire
Gas stove (duration) yrs. mos. one hrs.

18 Where was disease contracted if not at place of death? home
Did an operation precede death? no Date of
Was there an autopsy? No
What test confirmed diagnosis? Regular
(Signed) F. E. Luck, M. D.
Mar 25 1929 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery Balto md — DATE OF BURIAL Mch 28 29

20 UNDERTAKER Hornberger & Gross. — ADDRESS Benson md.

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44409

CERTIFICATE OF DEATH

100-001

E 44409

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 325 Stmdllwood ST., 20-69 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Earl E. Schreiner

(a) RESIDENCE NO. 325 Stmdllwd ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct 15-28

7 AGE — Years | Months: 5 Mo | Days: 11 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Earl E. Schreiner Jr

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Lodie Gross

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Earl E Schreiner Jr

(Address) 325 Stmdllwd

15 [illegible] 19 HAMPSON JONES, M. D. Registrar

R26 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 24/29

17 I HEREBY CERTIFY, That I attended deceased from March 22, 1929, to March 24, 1929, that I last saw him alive on March 24, 1929, and that death occurred, on the date stated above, at 10 30 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

Malnutrition

CONTRIBUTORY (Secondary) Otitis Media (duration) yrs. mos. 3 ds.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Herbert E Nelson, M. D.

3/25, 1929 (Address) 2157 Walbrook Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem.

DATE OF BURIAL: Mar 26, 1929

20 UNDERTAKER: John J Cowan & Son

ADDRESS: Gen Baltimore

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-002

E 44410

CERTIFICATE OF DEATH

E 44410

REGISTERED NO. 27-44

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2702 Halcyon Ave ST. (AVE.)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John L McKeown

(a) RESIDENCE NO. 2702 Halcyon Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Mary McKeown

6 DATE OF BIRTH (month, day, and year) Oct 10 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	6	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 073

(b) General nature of industry, business, or establishment in which employed (or employer) Engineer

(c) Name of employer R R.

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John McKeown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Reilly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Joseph Kelly

(Address) 2702 Halcyon Ave

15 Filed MAR 26 1929 16 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23 1929

17

I HEREBY CERTIFY, That I attended deceased from Jan 19, 1929, to Mar 23, 1929, that I last saw h alive on Mar 22, 1929 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Senility (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward Lees M. D.

Mar 25, 1929 (Address) 1216 E Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Mar 26 1929
20 UNDERTAKER	ADDRESS
Mary M. Wiedefeld	201 E 22nd St

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44411

CERTIFICATE OF DEATH.

101-001

E 44411
REGISTERED NO.

1-PLACE OF DEATH West Baltimore General

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST. 16-22 (WARD)

2-FULL NAME Foster Howard.

(a) RESIDENCE No. 1119 N. Gilmor ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	M

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Moulder

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER Frank Howard

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Pastus Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant
(Address)

15 Filed MAR 26 1929 19 Reg. No. 3108 J. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/23, 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb. 24, 1929, to March 23, 1929.

that I last saw h alive on March 23, 1929

and that death occurred, on the date stated above, at 7:00 P. m

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Acute Dilatation of Heart

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jack [illegible] M. D.

3/23, 1929 (Address) West Balto. General.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health

ADDRESS

MAR 25 1929

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44412

CERTIFICATE OF DEATH

161-002

E 44412

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1414 Rutter St. 14-20 Ward)

2-FULL NAME Ernest Thornton

(a) RESIDENCE NO. 1414 Rutter St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	Col.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of No.

6 DATE OF BIRTH (month, day, and year) Mar 11 1929

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
			12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Lucius Thornton

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Carrie Thompson

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Lucius Thornton
(Address) 1414 Rutter

15 Filed MAR 26 1929 HAMPSON JONES, M. D. Registrar

3404

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Mar 23rd 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Cerebral Congestion

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Due to delivery.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Regular

(Signed) H. H. Leech, M. D.
Mar 24 1929 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

Commissioner Health

UNIVERSITY OF MARYLAND

MAR 25 1929

Pub. Pts. B. Wood Co.

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 44413 HEALTH DEPARTMENT—CITY OF BALTIMORE 58-001 **E 44413**

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Md University Hosp ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Woodward

(a) RESIDENCE NO. 3524 Elm St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced. HUSBAND of (or) ~~WIFE~~ of Almira L. Woodward

6 DATE OF BIRTH (month, day, and year) Dec. 12 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	69	3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Jacob Woodward

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Hannah Broadbeck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Almira L Woodward

(Address) 3524 Elm Ave

Filed MAR 20 1929 H. C. HAMPSON JONES, M. D.

By Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 13, 1929, to March 24, 1929, that I last saw him alive on March 24, 1929 and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical tests

(Signed) Bryan N. Roberts, M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge DATE OF BURIAL Mar 26 1929

20 UNDERTAKER A S Marshall ADDRESS 3539 Falls Rd

Spec.—1-10-21—M&T—1500 Bks.

E 44414

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44414

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 219 S Fremont ST. 22-29 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amanda Graves,

(a) RESIDENCE NO. 219 S. Fremont ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of Foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	colored.	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
61 60				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work. 10

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Montgomery (State or country) Alabama

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown (State or country)

14 Informant Blanch S. Cotton. (Address) 219 S. Fremont Ave.

15 Filed ..... 19 HAMPSON JONES, M. D. Registrar

MAR 25 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 21 1929

17 I HEREBY CERTIFY, That I attended deceased from Mar 18, 1929, to Mar. 21, 1929, that I last saw h[illegible] alive on Mar 20, 1929 and that death occurred, on the date stated above, at 2-15 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Ruby Young, M. D.

3-23, 1929 (Address) 729 Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL mount calvary — DATE OF BURIAL Mar 25 1929

20 UNDERTAKER Edward Bryan — ADDRESS 1631 Orleans

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44415

CERTIFICATE OF DEATH

31

E 44415

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Baltimore City Hospitals ST., 1927 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Drucilla Bennett

(a) RESIDENCE NO. 1703 W. Franklin st. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Separated

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) March 1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26	0	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Henry Wise

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Anna Wise

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records

(Address)

15 Filed MAR 26 1929, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 19, 1928, to March 24, 1929, that I last saw her alive on March 24, 1929 and that death occurred, on the date stated above, at 2.30 a. m.

The CAUSE OF DEATH* was as follows:

Acute pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) Henry Smith, M. D.

3-25, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Auburn — DATE OF BURIAL: 3-27 1929

20 UNDERTAKER: Joseph A. Lively — ADDRESS: 4091 N. Mount St.

Spec.—2-29-28—L. F. S.—500 Bks.

Dr Moody. 1403 Portland

E 44416 HEALTH DEPARTMENT—CITY OF BALTIMORE 101-001 E 44416

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1204 N Charles ST. 11-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles E Smith

(a) RESIDENCE NO. 1204 N Charles ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced HUSBAND of (or) WIFE of: Sadie L Smith

6 DATE OF BIRTH (month, day, and year): June 15, 1881

7 AGE: Years 47 | Months 9 | Days 4 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Police Officer 061

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Baltimore City

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Edward F. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Mary A Webster

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Edward F Smith

(Address): 1204 N Charles St

15 [illegible] 19 HAMPSON JONES, M. D. Registrar

R 26329

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 25 1929

17 I HEREBY CERTIFY, That I attended deceased from 3/20/29 19 to 3/25/29 19, that I last saw him alive on 3/24/29 19, and that death occurred, on the date stated above, at 3:25 A.M.

The CAUSE OF DEATH* was as follows:

Brain Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical findings

(Signed) W. A. Moody M. D.

19 (Address) 1403 Portland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore

DATE OF BURIAL: 3/27 19 29

20 UNDERTAKER: [illegible] & Cook

ADDRESS: 1219 St Paul St

Spec.—2-29-28—L. F. S.—500 Blks.

Dr Aitchinson 4012 Park Heights Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

E 44417 — CERTIFICATE OF DEATH — **E 44417**

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3129 Cold Spring Ave ST., 27-26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Hester A Meyers

(a) RESIDENCE NO. 3129 Cold Spring Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. 9 mos. 25 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 Female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Meyers

6 DATE OF BIRTH (month, day, and year) Aug 20, 1861

7 AGE — Years 67 | Months 9 | Days 4 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) Martinsburg (State or country) W. Va

PARENTS

10 NAME OF FATHER Henry Matthews

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va

12 MAIDEN NAME OF MOTHER Mary Richards

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va

14 Informant Carrie Ringgold

(Address) 3129 Cold Spring Ave

15 Filed MAR 26 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 24, 1929

17 I HEREBY CERTIFY, That I attended deceased from Mar. 17, 1929, to Mar 24, 1929

that I last saw her alive on Mar 24 1929

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Right Hemiplegia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James S. Aitchinson, M. D.

3-25-1929 (Address) 4012 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvert — DATE OF BURIAL 3-27-29

20 UNDERTAKER Wm Cook — ADDRESS 2127 Ford

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44418

CERTIFICATE OF DEATH

129

E 44418

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 14 Wheeler Ave ST. 30-69 (WARD)

2—FULL NAME William N. Birkett

(a) RESIDENCE NO. 14 (Usual place of abode) Wheeler Ave ST., WARD

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Willie S. Birkett

6 DATE OF BIRTH (month, day, and year) Feb 6. 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	78	1	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Thomas N. Birkett

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Mary Schemp

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Willie S. Birkett

(Address) 14 Wheeler Ave

15 MAR 26 1929 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 24. 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1921, to March 1929, that I last saw him alive on March 22 1929, and that death occurred, on the date stated above, at 10-52 a.m.

The CAUSE OF DEATH* was as follows:

Generalized Arterio Sclerosis

Myocardial Degeneration

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wounded M. D.

Mch 25 1929 (Address) 2401 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cem. DATE OF BURIAL Mar 26 1929.

UNDERTAKER Funl Mrs. John H Deupel & Son ADDRESS 101 W. Fayette St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44419 E 44419

CERTIFICATE OF DEATH.

161-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Bon Secours Hospital (WARD) 12-52

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Rita Reynolds

(a) RESIDENCE NO. 3616 Roland Ave. WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): Mar 24 1928

7 AGE — Years — Months — Days: 1 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Chas G. Reynolds

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Mary Catherine Turton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Chas G. Reynolds
(Address) 3616 Roland Ave

15 Filed ..... 19..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/25 1929

17

I HEREBY CERTIFY, That I attended deceased from March 24 1929 to March 25 1929.

that I last saw h alive on March 25 1929,

and that death occurred, on the date stated above, at 12.5 P.M.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis
Cerebral Hemorrhage

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Physical exam

What test confirmed diagnosis?

(Signed) Thos E Stacy Jr. M. D.

19 (Address) 2003 Alfred St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL 3/27 1929

20 UNDERTAKER: Chas P. Ivanhoe — ADDRESS 1810 Mt Royal Ave

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44420

CERTIFICATE OF DEATH

11-001

E 44420

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 1704 Ellsworth ST. (8-11 WARD)

2—FULL NAME Charles Linburg Geary

(a) RESIDENCE NO. 1704 Ellsworth ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	C.	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 7, 1928

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	5	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Lucken Geary

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Ellen Hanes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Geary Lucken

(Address) 1704 Ellsworth St.

15 Filed [illegible] HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/25/29

17 I HEREBY CERTIFY, That I attended deceased from 3/19, 1929, to 3/24, 1929

that I last saw h[illegible] alive on 3/24/, 1929

and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Medical Test

(Signed) H. Wallen, M. D.

, 19 (Address) 1511 W Mulberry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Calvary	March 26 1929
UNDERTAKER Mrs. K. G. Elliott	ADDRESS 1723 Eastland Ave

Spec.—1-10-21—M&T—1500 Blks.

44421

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

125 E 44421

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH United States Marine Hospital,

CITY OF BALTIMORE: (No.) Baltimore, Maryland. ST. (Ward) 20-28

2-FULL NAME John R. Ridgeway

(a) RESIDENCE No. 1927 W. Pratt Street, Balto., ~~St.~~ Md. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs. 5 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Married - separated

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Lillian Donaldson

6 DATE OF BIRTH (month, day, and year) Oct.8,1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer) Barber

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER John Ridgeway

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Laura Potee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14

Informant U.S. Marine Hospital records

(Address) Baltimore, Maryland.

15

Filed 3-25, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23 19 29

17

I HEREBY CERTIFY, That I attended deceased from March 20 19 29 to March 23 19 29

that I last saw him alive on March 23 19 29

and that death occurred on the date stated above, at 11:10 A. m.

The CAUSE OF DEATH* was as follows:

Acute hemorrhagic pancreatitis

(duration) yrs. mos 13 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of Mar. 22'29

Was there an autopsy? Yes

What test confirmed diagnosis? Operation & autopsy

(Signed) [illegible] M. D.

3/23 19 29 (Address) U.S. Marine Hospital, Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cem. | DATE OF BURIAL: March 26 19 29

20 UNDERTAKER: Harry A. Nitzke | ADDRESS: 1531 W. Lombard

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 44422

37-002

E 44422

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Baltimore City Hospitals (ST.) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Robert Noail

(a) RESIDENCE NO. 208 Vernal court ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS.

10 NAME OF FATHER Allen Noail

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Sarah ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records

(Address)

15 R 2-6 1929 C. 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 23, 1929, to March 24, 1929, that I last saw him alive on March 24, 1929 and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Acute disseminated tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Henry Smith, M. D.

3-25. 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet

DATE OF BURIAL March 27 1929

20 UNDERTAKER Kendall & Lippert

ADDRESS 300 N. Eden St.

Spec.—2-29-28—L. F. S.—500 Bks.

E 44423

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 44423

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3110 E. Gibbons ave ST., 39th WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth A. Kirkpatrick

(a) RESIDENCE NO. 3110 E. Gibbons ave ST., Hamilton WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Reuben M. Kirkpatrick

6 DATE OF BIRTH (month, day, and year) Aug. 19 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	7	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Co. (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Frankie A. Kirkpatrick (Address) 3609 Pilgrim Rd.

15 Filed , 19 HARPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25th 1929

17 I HEREBY CERTIFY, That I attended deceased from March 17, 19 29, to March 25, 19 29

that I last saw her alive on March 25, 19 29

and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pleurisy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Hyde & Golding, M. D.

, 19 (Address) 5103 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	March 28 29
20 UNDERTAKER	ADDRESS
Frederick Lassahn & Sons	Fullerton

Spec.—2-29-28—L. F. S.—500 Bks.

E 44424 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 **E 44424**

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3109 Belair road ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Raymond N. Bruff

(a) RESIDENCE NO. 3109 Belair road ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 7/86

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	4	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Taxi Driver

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Premier Cab Co

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER J. O. Bruff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Katie E. Sapp

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Katie E. Bruff

(Address) 3109 Belair rd

15 Filed MAR 26 1929 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 24/29

17 I HEREBY CERTIFY, That I attended deceased from Mar 23, 1929, to Mar 24 1929

that I last saw h alive on Mar 24, 1929,

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Asthma

Myocarditis Chronic

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) E. Howard Donald, M. D.

, 19 (Address) 817 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem. DATE OF BURIAL 3/27 1929

20 UNDERTAKER Philip Herrig ADDRESS 206 Orleans St

Spec.—2-29-28—L. F. S.—500 Bks.

E 44425 HEALTH DEPARTMENT—CITY OF BALTIMORE 129 **E 44425**

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 123 E. Clement St. ST. 24-33 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret Peters

(a) RESIDENCE NO. 123 E. Clement St. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Casper A. Peters

6 DATE OF BIRTH (month, day, and year) Nov. 19 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80	4	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Michael Pfeiffer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Henry Peters

(Address) 123 E. Clement St

15 MAR 26 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-25-1929

17 I HEREBY CERTIFY, That I attended deceased from Feb 19, 19 29, to Mar 25, 19 29, that I last saw ~~her~~ alive on Mar 25, 19 29 and that death occurred, on the date stated above, at 5-30 P m.

The CAUSE OF DEATH* was as follows:

Chronic int. nephritis with high tension

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery

DATE OF BURIAL 3/28 1929

20 UNDERTAKER J. Tom McCully

ADDRESS 130 E. Fort.

Cor.—10-10-29—A Co.—100 Bks.

E 44426

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 44426

REGISTERED NO. 13-59

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Md Gen Hosp (Ward)

2-FULL NAME Jacob Lipsitz

(a) RESIDENCE NO. 2427 Linden St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah.

6 DATE OF BIRTH (month, day and year) 1860

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	68			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Merchant.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Russia
(State or country)

PARENTS

10 NAME OF FATHER Nathan

11 BIRTHPLACE OF FATHER (city or town) Russia
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Russia
(State or country)

14 Informant Harry Lipsitz
(Address) 2427 Linden Ave

15 Filed APR 6 1929 HAMPSON JONES, M. D. Registrar
By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) March 26th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Diabetes

(duration) one yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 2427 Linden Ave

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) M. D. Coroner.

March 26 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Southern ave — DATE OF BURIAL 3/26 1929

20 UNDERTAKER Ant Florian & Bro — ADDRESS 1127 E Balto st

IMPORTANT—Space must be filled in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

E 44427 HEALTH DEPARTMENT--CITY OF BALTIMORE E 44427

CERTIFICATE OF DEATH

105

1 PLACE OF DEATH Rwandale REGISTERED NO. C

CITY OF BALTIMORE (No. Hebrew Aged Home St. 15-68 WARD)

(If death occured in a hospital or institution give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Hyman Shoffer

(Residence in Baltimore: No. 2209 Presbury st St.: 40 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~SINGLE~~, MARRIED, WIDOWED OR DIVORCED (Write the word): Wid

6 DATE OF BIRTH: ....., 1844 (Month) (Day) (Year)

7 AGE: 85 yrs. — mos. — ds. If LESS than 1 day, ... hrs. or — min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: none 600
(b) General nature of industry, business, or establishment in which employed (or employer): .....

9 BIRTHPLACE (State or country): Russia

PARENTS

10 NAME OF FATHER: Morris Shoffer

11 BIRTHPLACE OF FATHER (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (State or country): Russia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Isaac Shoffer

(Address) 92 Madison ave

15 Filed MAR 26 1929 C. HAMPSON JONES, M. D. REGISTRAR

Det Hill

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: March - 25 -, 1929 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from March - 2 -, 1929, to March - 25 - 1929, that I saw h[im] alive on March - 25 -, 1929, and that death occurred, on the date stated above, at 7 45 p.m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

No autopsy.

(Duration) about yrs. 2 mos. ds.

Contributory (SECONDARY) Bronchial asthma

(Duration) yrs. 2 mos. ds.

(Signed) Herman Seidel M. D.

March - 25 -, 1929 (Address) Herman Seidel

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Hebrew Mt Carmel Rd DATE OF BURIAL: 3/26 19[illegible]

20 UNDERTAKER: Sol Levinson Bro ADDRESS 1127 E Balto st

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 44428

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

E 44428

1—PLACE OF DEATH University Hospital — REGISTERED NO. 21-29

CITY OF BALTIMORE: (No. ... ST. ... WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Eugene Schultze

(a) RESIDENCE NO. 1216 S. Paca ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White German

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna Schultze

6 DATE OF BIRTH (month, day, and year): Aug. 3, 1862

7 AGE: Years 66 | Months 7 | Days 22 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Plumber 54

(b) General nature of industry, business, or establishment in which employed (or employer): Household Plumbing

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Eugene Schultze

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Weidler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Emma Lammon

(Address) 1314 Sargent St.

15 Filed ... 19 ... HAMPSON JONES, M. Registrar

MAR 26 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar. 25, 1929

17 I HEREBY CERTIFY, That I attended deceased from 3-24, 1929, to 3-25, 1929, that I last saw him alive on 3-25, 1929, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerotic Cardio-vascular disease

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Facts

(Signed) Bryan N. Potts, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: March 1929

20 UNDERTAKER: W. J. Luckmeyer Sons — ADDRESS: Mt. Royal Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44429

CERTIFICATE OF DEATH

90 E 44429

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1111 Valley ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Laurence Molloy

(a) RESIDENCE NO. 1111 Valley ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Katie O'Neill

6 DATE OF BIRTH (month, day, and year) June 10, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	9	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pres. 045

(b) General nature of industry, business, or establishment in which employed (or employer) Clough & Molloy

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Co. Wexford, Ireland

PARENTS

10 NAME OF FATHER Patrick Molloy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Anastasia Sinnott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Michael Molloy

(Address) 2823 Montebello Terrace

15 MAR 26 1929 SAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-24-29

17 I HEREBY CERTIFY, That I attended deceased, from March 17, 1929, to March 24, 1929, that I last saw him alive on March 24, 1929 and that death occurred, on the date stated above, at 1:05 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

Myocardial degeneration

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Myocardial degeneration

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) W. O. Faustin, M. D.

19 (Address) 16 Bradas

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral — DATE OF BURIAL: Mar. 27, 1929.

20 UNDERTAKER: P. J. Tredwell — ADDRESS 914 Greenmount Ave

Spec.—2-29-28—L. F. S.—500 lbs.

E 44430 HEALTH DEPARTMENT—CITY OF BALTIMORE E 44430

CERTIFICATE OF DEATH

129

1—PLACE OF DEATH

REGISTERED NO. 27-53

CITY OF BALTIMORE: (No. 220 Oakdale Road ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Agnes Getz

(a) RESIDENCE NO. 220 Oakdale Road ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

.a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 21, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	2	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John M. Getz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary R. Burgan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14

Informant Rose Getz

(Address) 220 Oakdale Road

15 Filed MAR 26 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24th 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 15th, 1929, to March 24th, 1929

that I last saw h alive on March 24th, 1929

and that death occurred, on the date stated above, at 3.30 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

" Uraemia Endocarditis

(duration) 1 yr. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Hobart Burch M. D.

3/25, 1929 (Address) 110 E. Club Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	Mar. 27 1929.

UNDERTAKER

ADDRESS

HAMILTON JONES, M. D.
Registrar

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44431 | CERTIFICATE OF DEATH | E 44431

24-001

1—PLACE OF DEATH

REGISTERED NO. 13-59

CITY OF BALTIMORE: (No. 2459 Druid Hill Ave ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Hester Rildeak

(a) RESIDENCE NO. 2459 Druid Hill Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if foreign birth? 59 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widow

6 DATE OF BIRTH (month, day, and year): 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: housework

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): N. Carolina

PARENTS

10 NAME OF FATHER: Arden Hobby

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. Carolina

12 MAIDEN NAME OF MOTHER: Rachel Deese

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. Carolina

14 Informant: Ernestine William Hunter

(Address) 2459 Druid Hill Ave

15 MAR 26 1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 24, 1929

17 I HEREBY CERTIFY, That I attended deceased from Mar 18th, 1929, to Mar 24, 1929, that I last saw her alive on May 23rd, 1929, and that death occurred, on the date stated above, at 12 noon

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): Arterio-sclerosis

Primary (duration) 2 yrs. — mos. ds.

18 Where was disease contracted if not at place of death? Balto. City

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual test

(Signed) W. Grant Pratt, M. D.

. 19 (Address) 2542 N. Fulton Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: 3-26 1929

20 UNDERTAKER: Daniel Foster — ADDRESS 916 Bond

Spec.—2-29-28—L. F. S.—500 Bks.

E 44432

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-002

CERTIFICATE OF DEATH

BALTIMORE CITY HOSPITALS

E 44432

REGISTERED NO.

1—PLACE OF DEATH [redacted]

CITY OF BALTIMORE: (No. ... ST., 4-7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Martha Robinson

(a) RESIDENCE NO. 123 Gay ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None 07

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Eddie Mack Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Records of BALTIMORE CITY HOSPITALS

(Address) [redacted]

MAR 26 1929

HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23, 1929

17

I HEREBY CERTIFY, That I attended deceased from February 18, 1929, to March 23, 1929, that I last saw h er alive on March 23, 1929 and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis
Decubitus ulcers
Septicemia

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [redacted], M. D.

, 19 (Address) BALTIMORE CITY HOSPITALS [redacted]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pleasant Hill DATE OF BURIAL 3/26 1929

UNDERTAKER Edmund Wensley ADDRESS 78 N Bridle

Spec.—1-12-23—M&T—500 Blks.

E 44433

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 E 44433

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1413 ½ Franklin ST. 14-27 (WARD)

2-FULL NAME Louisa Jackson,

(a) RESIDENCE No. 1413 ½ W Franklin ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	colored	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of David Jackson

6 DATE OF BIRTH (month, day, and year) Sept 11, 868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	60	6	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 0'0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Calvert Co. Md.

PARENTS

10 NAME OF FATHER Pierce Gant

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Co. Md

12 MAIDEN NAME OF MOTHER Adeline Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co Md.

14 Informant Sarah Jackson Thornton

(Address) 1413 ½ Franklin St.

15 Nedicine C. HAMPSON JONES, M. D.

Registrar

R 261929 Par

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23 1929

17

I HEREBY CERTIFY, That I attended deceased from Jan 3, 1929, to March 23, 1929, that I last saw h[illegible] alive on March 23, 1929, and that death occurred, on the date stated above, at 12 Noon

The CAUSE OF DEATH* was as follows:

Rectic Carcinoma

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) [illegible], M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ingold Cem Calvert Co Md

DATE OF BURIAL Mar. 28 1929

20 UNDERTAKER Mrs Katie R. Williams

ADDRESS 3224 Edmondson Ave.

THIS IS VERY IMPORTANT See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 44434

HEALTH DEPARTMENT—CITY OF BALTIMORE

11-092

E 44434

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1734 Division ST., 14-20 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Fannie S Price

(a) RESIDENCE NO. 1734 Division ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write this word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE: Years 62 | Months | Days | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Lexington Va

PARENTS

10 NAME OF FATHER: Robert N Price

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Martha A Slaven

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Robert E. Price

(Address): Boston Mass.

15 [illegible], 19 — C. HAMPSON JONES, Registrar

R26 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25 '29

17

I HEREBY CERTIFY, That I attended deceased from March 1 — , 1929, to March 25, 1929, that I last saw h[illegible] alive on March 24, 1929 and that death occurred, on the date stated above, at 11.15 A m.

The CAUSE OF DEATH* was as follows:

Acute glomerulonephritis

(duration) — yrs. — mos. 25 ds.

CONTRIBUTORY (Secondary): Broncho Influenza

(duration) — yrs. — mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no. Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinp + Chem.

(Signed) Chas J. Keller, M. D.

3/26, 1929 (Address) 222 W. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lexington Va — DATE OF BURIAL: March 26 29

20 UNDERTAKER: Samuel J Kennedy — ADDRESS: 5781 W Belle

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44435

101-001

E 44435

CERTIFICATE OF DEATH

1—PLACE OF DEATH University Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 24-23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Brady

(a) RESIDENCE NO. 1127 Riverside ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 5, 1913

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	15	4	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schoolboy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Thos. J. Brady

11 BIRTHPLACE OF FATHER (city or town) Balto, Md.
(State or country)

12 MAIDEN NAME OF MOTHER Laura M. King

13 BIRTHPLACE OF MOTHER (city or town) Balto., Md.
(State or country)

14 Informant Frank J. Brady

(Address) 1127 Riverside ave.

15 Filed 3 26 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 26, 1929

17 I HEREBY CERTIFY, That I attended deceased from 3-17, 1929, to 3-26, 1929, that I last saw him alive on 3-26, 1929 and that death occurred, on the date stated above, at 1:15 A.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) — yrs. — mos. 10 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical tests.

(Signed) Bryan U. Roberts, M. D.

March 27, 1929 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem. DATE OF BURIAL March 28 1929

20 UNDERTAKER M. J. Flynn ADDRESS 1422 Light St

Spec.—2-29-28—L. F. S.—500 Bks.

E 44436

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

E 44436

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Mt Hope Retreat St., 19-28 WARD). Sister Dominica

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Creaghan

(a) RESIDENCE NO. Mount Hollister St., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
65	67	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Religious

(b) General nature of industry, business, or establishment in which employed (or employer) 65

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Thomas Meagher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Carr

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Sister Superior (Address) Mount St Vincent

15 Filed 2 6 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/25/29

17

I HEREBY CERTIFY, That I attended deceased from June, 19 27 to Mch, 19 29, that I last saw h[illegible] alive on March 15, 19 29 and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Senile Arterio sclerosis, mitral regurgitation, Chronic Myocarditis, Mental Disorder

(duration) 11 yrs. mos. ds.

CONTRIBUTORY (Secondary) Angina pectoris

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Treatment

(Signed) Edward J. Mayer M. D.

, 19 (Address) 336 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL 3/27 19 29

20 UNDERTAKER J. F. Tracy & Sons

ADDRESS 318 Light St.

Cor.—10-10-29—A Co.—100 Bks.

E 44437

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 44437

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Room House 615 N. Pace St., 17-25 Ward)

2-FULL NAME — Creps.

(a) RESIDENCE NO. Unknown St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 2 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed or Divorced, (write the word): Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day and year): about 1888

7 AGE: Years 40 | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Unknown
(State or country)

PARENTS

10 NAME OF FATHER .....

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER .....

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Police Record
(Address) .....

15 Filed ....., 19.. G. HAMPSON JONES, M. D. Registrar

26 1929 THE MORGUE 3409

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): March 16 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

..... (duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. Colvin Jr. M. D.

Mar 25 1929 (Address) Coroner

*State the Disease causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL .....

DATE OF BURIAL 19 .....

20 UNDERTAKER Commissioner of Health

ADDRESS .....

MAR 26 192

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44438

CERTIFICATE OF DEATH.

E 44438

161-01

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST. 17-25 WARD)

2-FULL NAME Eddy Clark

(a) RESIDENCE NO. 421 N. Pine St. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 9 1929

7 AGE — Years: — Months: — Days: 28 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) ..... (State or country) U. S.

PARENTS

10 NAME OF FATHER John Young

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Ga.

12 MAIDEN NAME OF MOTHER Hattie Clark

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Ga.

14 Informant ..... (Address) Johns Hopkins Hospital

15 Filed MAR 26 1929 C. HAMPSON JONES, M. D. Registrar

3411

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 12 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb. 9, 1929, to Mar. 12, 1929, that I last saw her alive on Mar. 12, 1929, and that death occurred, on the date stated above, at 10.00 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) [signature] M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL ..... 19 .....

20 UNDERTAKER .....

ADDRESS .....

Commissioner of Health

MAR 26 1929

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44439

CERTIFICATE OF DEATH

E 44439

REGISTERED NO. 8-45

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1647 Cliftview Ave. ST. WARD)

2—FULL NAME Lottie Happ.

(a) RESIDENCE NO. 1647 Cliftview, Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. 27 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John H. Happ, Sr.

6 DATE OF BIRTH (month, day, and year) Feb, 27, 1865.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	64,		27.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: George H. Walper.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Wilhelminia Fleschter.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant: Linnie Happ. (Daughter)

(Address) 1647 Cliftview Ave.

15 [illegible] 19 HAMPSON JONES, M. D. Registrar

MAR 26 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 24 29.

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1928, to Mar. 24, 1929, that I last saw her alive on Mar. 24, 1929 and that death occurred, on the date stated above, at 9.25 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) S. Lee Madden, M. D.

3-25-29 (Address) 1206 E. Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Butchers Hill	Mar 27 19 29
20 UNDERTAKER	ADDRESS
A. Brand Sons	1 E. Fayette

Spec.—2-29-28—L. F. S.—500 Bks.

E 44440

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129

E 44440

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 412 Hawthorn ST., Roland Park WARD) Baltimore Maryland

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Anna Belden

(a) RESIDENCE NO. 412 Hawthorn Road ST., Roland Park WARD
(Usual place of abode) Maryland

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 8 mos. 26 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed, or Divorced~~, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of wife of Harry L. Belden

6 DATE OF BIRTH (month, day, and year) January 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68	3	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Gloucester Massachusetts

PARENTS

10 NAME OF FATHER George Clark

11 BIRTHPLACE OF FATHER (city or town) Gloucester (State or country) Massachusetts

12 MAIDEN NAME OF MOTHER Elizabeth Tucker

13 BIRTHPLACE OF MOTHER (city or town) Gloucester (State or country) Massachusetts

14 Informant George Clark Belden

(Address) 412 Hawthorn Road Roland Park, Md.

15 Filed MAR 26 1929 Geo. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26 - 1929.

17 I HEREBY CERTIFY, That I attended deceased from Mar. 6, 1929, to Mar. 26, 1929, that I last saw her alive on Mar. 26, 1929 and that death occurred, on the date stated above, at 8-45 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis with Decompensation. Chronic Nephritis with Edema and Uremia

(duration) 2+ yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia - Uremic Coma

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) M. Tilton Porter, M. D.

3/26. 1929 (Address) 422 Roland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Boston Mass.

DATE OF BURIAL 3/27/29

20 UNDERTAKER Henry W. Jenkins Sons Co.

ADDRESS Orchard & McCulloh

Spec.—2-29-28—L. F. S.—500 Bks.

223792
~~B~~ 44441

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

+ 43 E 44441

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. ... ST., 7-9 WARD) REGISTERED NO. ...

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Benjamin Manning

(a) RESIDENCE NO. Winterville ST., N-Car- WARD
(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. 9 ds. How long in U. S., if foreign birth? ... yrs. ... mos. ... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

.a If married, widowed, or divorced HUSBAND of (or) WIFE of Hattie

6 DATE OF BIRTH (month, day, and year) 4-27-65-

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	65-			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Buying & Trading Cotton

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9 BIRTHPLACE (city or town) (State or country) N-Car-

PARENTS

10 NAME OF FATHER Charles Manning

11 BIRTHPLACE OF FATHER (city or town) (State or country) N-Car-

12 MAIDEN NAME OF MOTHER Christian Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N-Car-

14 Informant Friends
(Address) JOHNS HOPKINS HOSPITAL

15 Filed 26 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26-29

17 I HEREBY CERTIFY, That I attended deceased from March 17, 1929 to March 26, 1929, that I last saw him alive on March 24, 1929 and that death occurred, on the date stated above, at 2 30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Mouth

(duration) ... yrs. 6 mos. ... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia.

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? in North Carolina

Did an operation precede death? no. Date of ...

Was there an autopsy? no

What test confirmed diagnosis? Biopsy.

(Signed) George E Denney, M. D.

March 26 1929 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rocky Mount N. C.	March 26 29
20 UNDERTAKER	ADDRESS
Williams & Schaffer	816 Monument

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44442 161-001 **E 44442**

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 500 N. Steiner ST., 17-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anita Edna Hasenei

(a) RESIDENCE NO. 500 N. Steiner ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced (write word)

6 DATE OF BIRTH (month, day, and year) Jan. 26-29

7 AGE Years Months Days If LESS than 1 day 3 hrs. or 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt

PARENTS

10 NAME OF FATHER James E Hasenei

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt

12 MAIDEN NAME OF MOTHER Agatis A Schott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Jas E Hasenei

(Address) 500 N. Steiner St

15 Filed 2 6 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 26 1929

17 I HEREBY CERTIFY, That I attended deceased from Mar 26, 19 , to Mar 26, 19 ,

that I last saw h alive on Mar 26, 19

and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Primary Birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm Jones, M. D.

19 (Address) 2958 E Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Int Baxmelbom — DATE OF BURIAL Mar 27 19 29

20 UNDERTAKER J. H. Horan — ADDRESS 502 E Baltimore

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 44443 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. **E 44443**

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1634 E. Preston St. St. (Ward) 8-17

2-FULL NAME Julia E. Miller

(a) RESIDENCE. No. Hanover Ag Va St., Ward.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced (or) WIFE of: Newton Miller

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 57; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Rapids Iowa

PARENTS

10 NAME OF FATHER: Wm Lambert

11 BIRTHPLACE OF FATHER (city or town) (State or country): Iowa

12 MAIDEN NAME OF MOTHER: Himes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: George Miller
(Address) 1634 E Preston St

15 Filed MAR 26 1929 C. HAMPSON JONES, M. D. Registrar
By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 26 1929

17 I HEREBY CERTIFY, That I attended deceased from Mar 22 1929. to Mar 26 1929.
that I last saw her alive on Mar 26 1929.
and that death occurred, on the date stated above, at m.
The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary): Myocardial Insuff. Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm G. Layer, M. D.

. 19 (Address) 156 N. Milton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Harrisonburg Va

DATE OF BURIAL: Mar 28 1929

20 UNDERTAKER: Henry W. Meursdon

ADDRESS: 805 N. Calvert St.

IMPORTANT. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 44444

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 44444

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 906 N. Howard St., 11-24 Ward)

2-FULL NAME Mary Ormond

(a) RESIDENCE NO. 906 N. Howard (Usual place of abode) Ward

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 Color or Race White

5 Single, Married, Widowed or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Michael F.

6 DATE OF BIRTH (month, day and year) 1863

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	63			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Ireland
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Michael Ormond
(Address) 906 N. Howard

15 Filed [illegible] 1929 C. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 24 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
(duration) yrs. 3 mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Required

(Signed) H. G. Smith M. D.

Mar 25 1929 (Address) Coroner N. W. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cem Cathedral — DATE OF BURIAL 3/27 1929

20 UNDERTAKER W. Cook — ADDRESS 1217 St Paul

APR 27 1929

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 44445 HEALTH DEPARTMENT—CITY OF BALTIMORE E 44445

CERTIFICATE OF DEATH. X-97-02

1-PLACE OF DEATH St. Agnes Hospital

CITY OF BALTIMORE: (No. Caton & Wilkens Aves St. 75-72 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Mary Stouter

(a) RESIDENCE NO. Emmitsburg Md ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 28 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
46	45	6	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Emmitsburg

PARENTS

10 NAME OF FATHER Michael Stauter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Koch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt. Md

14 Informant Barbara Stauter

(Address) Emmitsburg Md

Filed APR 27 1929 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-26- 1929

17

I HEREBY CERTIFY, That I attended deceased from 3-14 —, 1929, to 3-26 A, 1929.

that I last saw her alive on 3-26 —, 1929,

and that death occurred, on the date stated above, at 3 50 P m.

The CAUSE OF DEATH* was as follows:

Ca. of Sarcoma of Breast with drainage in Nose pharynx

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary) Oedema of Epiglottis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy.

(Signed) Charles E. Bodell, M. D.

, 19 (Address) St. Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Emmitsburg Md.	March 30 1929
20 UNDERTAKER	ADDRESS
Frank A. Fink	915 N. Gay St.

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 44446 HEALTH DEPARTMENT—CITY OF BALTIMORE **E 44446**

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2023 N. Smallwood ST. 15-68 (WARD)

2-FULL NAME Sophie W. Dietsch

(a) RESIDENCE NO. 2023 N. Smallwood ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 79 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: ~~X~~ Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 24/47

7 AGE: Years 79 Months 2 Days 28 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School teacher

(b) General nature of industry, business, or establishment in which employed (or employer): retired 066

(c) Name of employer: Balto. School Board.

9 BIRTHPLACE (city or town) (State or country): Baltra. Md.

PARENTS

10 NAME OF FATHER: Friedrich Dietsch

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Wilhelmina Demeres

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Old German Bible

(Address)

15 Filed MAR 27 1929 H. C. HAMPSON JONES, M. D. Registrar

Bar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 24 1929

17 I HEREBY CERTIFY, That I attended deceased from May 21, 1923, to Mar 24, 1929.

that I last saw h[illegible] alive on Mar 24, 1929,

and that death occurred, on the date stated above, at 5.05 P. m.

The CAUSE OF DEATH* was as follows:

Chronic endocarditis + arteriosclerosis

(duration) 6 yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? usual tests

(Signed) H. E. Knipp, M. D.

3/25, 1929 (Address) 4025 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery

DATE OF BURIAL: 3/27 1929

20 UNDERTAKER: H. Womeso & Son.

ADDRESS: 805 N. Calvert St

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44447

CERTIFICATE OF DEATH

90 E 44447

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1310 E Layfatte ST. 9-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME W. allen Martin

(a) RESIDENCE NO. 1310 E Layfatte ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred [illegible] mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Maddie Martin.

6 DATE OF BIRTH (month, day, and year) August 28 1848

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
80	6	23 25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter 015

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Robert. Morris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Maddie C. Martin
(Address) 1310 E Layfatte av

15 C. HAMPSON JONES M.D. Registrar

R 27 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 23/29

17 I HEREBY CERTIFY, That I attended deceased from May 12, 1929, to Mar 23, 1929, that I last saw h[illegible] alive on Mar 23, 1929 and that death occurred, on the date stated above, at 10 30 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

3/26, 1929 (Signed) Wallis W. White M.D.
(Address) 2800 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	3/27 1929.

20 UNDERTAKER Geng - F. Rutt ADDRESS 1732 Maryland av

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

10-002

E 44448 — **CERTIFICATE OF DEATH** — **E 44448**

1—PLACE OF DEATH — REGISTERED NO. 617

CITY OF BALTIMORE: (No. Sydenham Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME GLORIA ZULKOWSKI

(a) RESIDENCE NO. 1320 N. Chester ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. da. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 30, 1926

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2	7	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): Home — do

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Matthew Zulkowski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Minnie Borkman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Matthew Zulkowski
(Address) 1320 N. Chester St.

15 Filed MAR 27 1929 H. MASON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 26, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 21, 1929, to March 26, 1929, that I last saw her alive on March 26, 1929 and that death occurred, on the date stated above, at 5.20 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Diphtheria (Nasal, Tonsillar

(duration) yrs. mos. ds.

18 Where was disease contracted 808 - 5th St. Northeast
If not at place of death? Washington, D. C.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical findings & Blood puncture

(Signed) Addison Pratt Ruby, M. D.

3-26 1929 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Wartz Cemetery	Mar 27 1929

20 UNDERTAKER: August Rusch — ADDRESS: 2406 Ashland ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44449

CERTIFICATE OF DEATH

101-001

E 44449

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1610 N. Bethel ST. (8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank LeRay Richardson

(a) RESIDENCE NO. 1610 N Bethel ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed, or Divorced~~, (write the word)
male	white	married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Eva E Richardson

6 DATE OF BIRTH (month, day, and year) January 30 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	35	1	22 24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Comfort Station Attendant 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER George Richardson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Ida Feehay

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Y.

14 Informant Eva E Richardson
(Address) 1610 N. Bethel St.

15 Filed APR 27 1929 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24 1929

17 I HEREBY CERTIFY, That I attended deceased from Mar. 15 1929, to Mar. 24 1929, that I last saw h~~i~~m alive on March 24 1929 and that death occurred, on the date stated above, at 4 30 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Double Pneumonia

(duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) Heart failure

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edwin F. Fenby M. D.

3/24/1929 (Address) 1223 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bay View Cemetery	March 29 1929
20 UNDERTAKER Robt L Lunderdon	ADDRESS 4427 Broadway

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44450

CERTIFICATE OF DEATH.

90

E 44450 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 452 Ellchester ave ST. 19-50 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie F. Fredwar

(a) RESIDENCE No. 452 Ellchester ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nelson Fredwar

6 DATE OF BIRTH (month, day, and year) March 16, 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	0	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt Md

PARENTS

10 NAME OF FATHER Garrett Frankhan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt Md

12 MAIDEN NAME OF MOTHER Mary Garsuch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Clarence F. Fredwar
(Address) 452 Ellchester ave

15 Filed MAR 27 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/25 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry) were find that said deceased came to h death on the day stated above.

The CAUSE OF DEATH* was as follows:

Jaboulay
Disease of
Heart

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) John J. Morrison, M. D.
(Coroner.)
3/26, 1929 (Address) 3632 Roslindale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL March 27 1929

20 UNDERTAKER Robt F. Turner & Son

ADDRESS 2727 Edmondson

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44451

CERTIFICATE OF DEATH

E 44451

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO. 90

CITY OF BALTIMORE: (No. [redacted] ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary E. Holbrook

(a) RESIDENCE NO. 340 Cedar ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widd

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	79			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Wm Tice

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Phebia

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Friends
(Address) BALTIMORE CITY HOSPITALS

15 Filed [redacted] 19 [illegible] JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-25-29

17 I HEREBY CERTIFY, That I attended deceased from 2-11, 1929, to 3-25, 1929

that I last saw her alive on 3-25, 1929

and that death occurred, on the date stated above, at 6.50 P m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) H. Stitt Wirth, M. D.

, 19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Marys Hanover	March 27 1929.
20 UNDERTAKER	ADDRESS
Thomas Hodson	3610 Chestnut

Information See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 44452

1-PLACE OF DEATH

34001

E 44452

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of Baltimore: (No. Sinai Hospital St., 6-9 Ward)

2-FULL NAME Bessie Erdman

(a) RESIDENCE NO. 2002 E. Fayette St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	50			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Hous work
(b) General nature of industry, business, or establishment in which employed (or employer) 037
(c) Name of employer At home

9 BIRTHPLACE (city or town)
(State or country) Russia

PARENTS

10 NAME OF FATHER Aaron ------

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Harry Erdman
(Address) 2002 E. Fayette St

15 Filed ---- 19 ---- C. HAMPSON JONES, M. D. Registrar

Dep

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 20/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Apoplexy)

(duration) ..... yrs. ..... mos. 3 hrs. ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? ~~Spinal Puncture~~

(Signed) [illegible] M. D.

3/27/29 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem. DATE OF BURIAL 3/27 1929

20 UNDERTAKER Jack Lewis ADDRESS 1434 E Balt

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-20-28—L. F. S.—500 Bks.

E 44453

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129

E 44453

REGISTERED NO.

1—PLACE OF DEATH Provident Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1514 Division ST. 14-20 WARD)

2—FULL NAME Emma Plummer

(a) RESIDENCE NO. 1925 Mc Culloh ST.. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: Colored | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown 1868

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
61	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic 097

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Unknown Va.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Sister Marie Rayner

(Address) 1917 McCulloh St

15 Filed MAR 27 1929 C. CHAMPION JONES, M.D. Registrar

by Ruth

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 26, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 21, 1929, to March 26, 1929, that I last saw h[illegible] alive on March 26, 1929 and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Hypertension

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary): Ch. Nephritis

(duration)? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) W. B. Butler, M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loan Mem. Pk. | DATE OF BURIAL: 3/27 1929

20 UNDERTAKER: Samuel Hewsley | ADDRESS 578 N Bdle

Important.—See instructions on the back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 44454 HEALTH DEPARTMENT—CITY OF BALTIMORE E 44454

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

City of BALTIMORE: (No. 123 N. Amity St. 18-26 Ward) Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harrison Ransom alias Garrison Jenkins

(a) Residence No. 123 N. Amity St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. 2 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Col.

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Elnene Ransom

6-DATE OF BIRTH (month, day and year): Aug. 16, 1897

7-AGE: 31 yrs. 7 mos. 9 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer): 040

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Balto. Md.

PARENTS.

10-NAME OF FATHER: Nathaniel Jenkins

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Balto, Md.

12-MAIDEN NAME OF MOTHER: Lottie Ransom

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Balto Md.

11- (Informant) Elnene Ransom

(Address) 123 N. Amity St.

15- Filed MAR 27 1929 19 THOMPSON JONES, M. D. Registrar.

By

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 3-24-29

17- I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1929 to March 24 1929 that I last saw her alive on March 24, 1929, and that death occurred, on the date stated above, at 8.20 P. m.

The CAUSE OF DEATH* was as follows:

Cardio-renal disease

(Duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia,

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab. & clinical

(Signed) H. Marco Williams, M. D.

3-26, 1929 (Address) 1630 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: National Cem. DATE OF BURIAL: 3-27 19 29

20-UNDERTAKER: Samuel Newsler ADDRESS: 1512 Lee

instructions on back of certificates. See

Spec.—2-29-28—L. F. S.—500 Bks.

E 44455

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

CERTIFICATE OF DEATH

E 44455

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1720 Cairo ST. 14-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Nellie Viola Hall

(a) RESIDENCE NO. 1720 Cairo ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 11 mos. 29 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Infant

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 31, 1927

7 AGE Years	Months	Days 26	If LESS than 1 day, hrs. or min.
1	11	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Clarence Hall

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Virginia Fields

13 BIRTHPLACE OF MOTHER (city or town) Middlesex
(State or country) Va.

11 Informant Clarence Hall
(Address) 1720 Cairo St.

15 Filed MAR 7 1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 26 1929

17 I HEREBY CERTIFY, That I attended deceased from Mar. 21, 1929, to Mar. 26, 1929 that I last saw her alive on Mar. 26, 1929 and that death occurred, on the date stated above, at 3 p.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Exposure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) Walter J. Jackson, M. D.

19 (Address) 1631 W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Mar 27 1929
UNDERTAKER Thomas E. Kelson	ADDRESS 1303 Pennsylvania Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

E 44456

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44456

CERTIFICATE OF DEATH.

15-24-001

Registered No. .....

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1303 N. Carey St., 15-23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Lizzie Randolph

(a) Residence No. 1303 N. Carey St., ... Ward .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, Colored

5-~~Single~~, Married, ~~Widowed, or Divorced~~, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. Randolph

6-DATE OF BIRTH (month, day and year) 1878

7-AGE, 51 yrs. ... mos. ... ds.

If LESS than 1 day, ... hrs. or ... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Domestic

(b) General nature of industry, business, or establishment in which employed (or employer). 037

(c) Name of employer. .....

9-BIRTHPLACE (city or town) (State or Country), Richmond, Va.

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Va

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Va

11- (Informant) Albert Randolph

(Address) 657 N. Paca St.

13- Filed ... 19... C. HAMPSON JONES, M. D. Registrar.

MAR 27 1929

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) March 25, 1929

17- I HEREBY CERTIFY, That I attended deceased from March 25, 1929 to March 25, 1929 that I last saw h[illegible] alive on March 25, 1929 and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) None

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) John D. Pullman, M. D.

Mar. 26, 1929 (Address) 1501 N. Fulton Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn cemetery	Mar 27, 1929
20-UNDERTAKER	ADDRESS
Thomas E Kelson	1303 Eutaw St

Instructions on back of certificates.

Statements are required by law, and must be answered. Exact statement of OCCUPATION is very important. See

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44457

CERTIFICATE OF DEATH

E 44457

74-00?

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., 91-64 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Clarence Fuget

(a) RESIDENCE NO. 2125 McHenry St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 34 yrs. 5 mos. 10 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of: Helen R Fuget

6 DATE OF BIRTH (month, day, and year): Oct 16, 1894

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
34	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Bartlett Hayward

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Louis Fuget

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Ida Bull

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Helen R Fuget

(Address) 2125 McHenry St

15 Filed ..., 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3-26-29

17

I HEREBY CERTIFY, That I attended deceased from 3-19-29, 19.., to 3-26-29, 19.., that I last saw h[illegible] alive on 3-21-29, 19.., and that death occurred, on the date stated above, at 8 00 AM m.

The CAUSE OF DEATH* was as follows:

Cellulitis of Mouth-following
infected molar tooth

CONTRIBUTORY (Secondary) Cerebral embolism (duration) yrs. mos. 1 ds.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 3-20-29

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C E Zumm, M. D.

, 19.. (Address) St Joseph Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: H S Rahm — DATE OF BURIAL: 3-28-29

20 UNDERTAKER: H Cook — ADDRESS: 1217 E Pratt St

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Hks.

Dr Burpee 1928 N Fulton La 3689

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44458

CERTIFICATE OF DEATH

90 E 44458

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2814 Erdman Ave ST. 16-64 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Irvin A Penn

(a) RESIDENCE NO. 2814 Erdman Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Ethel L Penn

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
47	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter 015

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Mayor Engineering Co

9 BIRTHPLACE (city or town) (State or country) Md U.S.

PARENTS

10 NAME OF FATHER Virgin Penn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md U.S.

12 MAIDEN NAME OF MOTHER Olivia Mankins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md U.S.

14 Informant Ethel L Penn

(Address) 2814 Erdman Ave

15 Filed MAR 27 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 26 1929

17 I HEREBY CERTIFY, That I attended deceased from 1 - 1 1928 to 3 - 26 1929, that I last saw him alive on 3 - 24 1929 and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 2 yrs. - mos. - ds.

CONTRIBUTORY (Secondary) Acute Bronchitis (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Phys. Exam

(Signed) Wilson L Burpee M. D.

3/28, 1929 (Address) 1998 N Fulton Ave Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bethel, Carroll Co Md

DATE OF BURIAL 3/28/1929

20 UNDERTAKER H. A. Cook

ADDRESS 1217 E Fayette St

Spec.—1-12 23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 44459

E 44459

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2610 Francis St. (Ward) 13-59

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Schumacher

(a) RESIDENCE NO. 2610 Francis ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of: John Louis Schumacher

6 DATE OF BIRTH (month, day, and year): Sept 30/1860

7 AGE: Years 68 Months 5 Days 23 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: John Zimmerman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Margaret Kennedy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Fred Schumacher

(Address): 14 Linganore Parkville

15 Filed MAR 27 1929 THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 24 1929

17

I HEREBY CERTIFY, That I attended deceased from Jan 25, 1929, to Mar 24, 1929.

that I last saw her alive on March 23, 1929

and that death occurred, on the date stated above, at 5:15 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cervix

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-Ray + Phy. diagnosis

(Signed) J. Schwerbrock M. D.

3/25, 1929 (Address) 401 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery

DATE OF BURIAL: 3/27/1929

20 UNDERTAKER: Fr. Weber & Son

ADDRESS: 2503 Edmondson Ave

TION is very important See instructions on back of certificate. Exact statement of OCCUPA-

Spec.—2-29-28—L. F. S.—500 Bks.

E 44460

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001

E 44460

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 203 S. Washington ST., 2-nd WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Walter Kenneth Yeager

(a) RESIDENCE NO. 203 S. Washington ST., 2 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. 28 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 27th 1925

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		4	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md

PARENTS

10 NAME OF FATHER Wm. J. Yeager

11 BIRTHPLACE OF FATHER (city or town) Balto. Md.
(State or country)

12 MAIDEN NAME OF MOTHER Amanda Hurt

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md
(State or country)

14 Informant Wm. J. Yeager Father

(Address) 203 S. Washington St.

15 HAMPSON JONES, M. D.
Registrar

MAR 27 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mch. 25/29

17 I HEREBY CERTIFY, That I attended deceased from Mch 21, 1929, to Mch 25, 1929, that I last saw him alive on Mch 25 29, and that death occurred, on the date stated above, at 7:10 a.m.

The CAUSE OF DEATH* was as follows:

Tubar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. Hillard M. D.

3/25, 1929 (Address) 2149 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Cross Cemetery	Mch. 27th 1929
20 UNDERTAKER	ADDRESS
Lutz & Zeller	703 S. Mo. Ave

Important: See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 44461 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital ST., 15-58 WARD) 6

2-FULL NAME Baby Male Schochet

(a) RESIDENCE No. 2716 Gloucester ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

E 44461 REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3-24-29

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City Md

PARENTS

10 NAME OF FATHER Benj Schochet

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Minnie Wolf

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Jack Levis

(Address) 1439 E. Balto St

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/25 1929

17 I HEREBY CERTIFY, That I attended deceased from 3/24/29, 19 to 3-25 19 29, that I last saw h in alive on 3/25/29 PM 19, and that death occurred, on the date stated above, at 5.00 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorhage

Since Birth (duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) B J Cohen M. D.

19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Reburn Pikesdale — DATE OF BURIAL 3/27 1929

20 UNDERTAKER Jack Levis 1439 E Balto St — ADDRESS

AR 71029C RAMPSON JONES, M. D.

CAUSE OF DEATH must be stated in plain terms, so that it may be properly classified. EXACT statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44462

CERTIFICATE OF DEATH.

101-201

E 44462

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 1434 E. Fairmount ST. 5th WARD)

2-FULL NAME Marsie Breedlan

(a) RESIDENCE No. 1434 E. Fairmount av. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Nov. 30, 1908

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	20	3	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) O'Neill

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) S. C.

PARENTS

10 NAME OF FATHER Thomas Breedlan

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. C.

12 MAIDEN NAME OF MOTHER Hettie Dicks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. C.

14 Informant Hettie Breedlan

(Address) 1434 E. Fairmount av.

15 Filed MAR 27 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 23 1929

17 I HEREBY CERTIFY, That I attended deceased from Mar. 19, 1929, to Mar. 22, 1929, that I last saw him alive on Mar. 22, 1929 and that death occurred, on the date stated above, at 9 15 A m.

The CAUSE OF DEATH* was as follows: Tabes pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Calvert L. Green, M. D.

3-23-1929 (Address) 120 Cheapside St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cemetery

DATE OF BURIAL 3/27/29

20 UNDERTAKER George J. Pulk

ADDRESS 1735 Mary

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 44463 123 E 44463

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. [redacted] ST., 25 WARD)

2—FULL NAME Benjamin Taylor

(a) RESIDENCE NO. 410 Aliceanna ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widower

6 DATE OF BIRTH (month, day, and year) 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 410

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Benj. Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Ford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant [redacted] (Address) BALTIMORE CITY HOSPITALS

15 Filed APR 27 1929 C. HAMPSON JONES M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/26/29

17 I HEREBY CERTIFY, That I attended deceased from 3/10, 1929, to 3/26, 1929, that I last saw h alive on 3/26, 1929, and that death occurred, on the date stated above, at 7.10 P m.

The CAUSE OF DEATH* was as follows:

Gangrene Foot
Diabetes Mellitus

Ventricular (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Ventricular

Did an operation precede death? Yes Date of 3/17/29

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Findings

(Signed) R. M. Vick, M. D.

(Address) BALTIMORE CITY HOSPITALS, 19 [redacted]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Mar 29 29
20 UNDERTAKER	ADDRESS
H. B. Tupper	852 N Bond St

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44464

CERTIFICATE OF DEATH

100-001

E 44464

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3306 O'donnell ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Michael H. Nally

(a) RESIDENCE NO. 3306 O'donnell ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Josephine Nally

6 DATE OF BIRTH (month, day, and year) Dec. 25, 1877

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
51 52	3	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Standard Oil Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Wm. Nally

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Josephine Nally

(Address) 3306 O'donnell St

15 Filed ..... 19..... C. HAMPSON JONES, M. D. Registrar

MAR 27 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 24, 1929, to March 25, 1929, that I last saw him alive on March 25, 1929 and that death occurred, on the date stated above, at 6:15 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Chronic Emphysema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Henry B. Kelly, M. D.

3/26, 19 29 (Address) 2504 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem.

DATE OF BURIAL 3/28/1929

20 UNDERTAKER John G. Connelly

ADDRESS Essex

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 44465

HEALTH DEPARTMENT—CITY OF BALTIMORE

57

E 44465

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1823 N. Chester ST., 8-16 WARD)

2—FULL NAME James T Brice

(a) RESIDENCE NO. 1823 N. Chester ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary H Brice

6 DATE OF BIRTH (month, day, and year) Oct. 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Garage Proprietor

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Kent Co Md.

PARENTS

10 NAME OF FATHER Thos Brice

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Armilda Branchle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mary H Brice

(Address) 1823 N Chester St

15 Filed MAR 27 1929 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb 3, 1929, to March 25, 1929, that I last saw him alive on March 25, 1929 and that death occurred, on the date stated above, at .....m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

..... (duration) 2 yrs. 1 mos. 22 ds.

CONTRIBUTORY (Secondary) Diabetic Gangrene

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Paul Fisher, M. D.

3/26, 1929 (Address) 1823 N. Chester St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood	3/28 1929

20 UNDERTAKER Edward Toulson

ADDRESS 2309 Ward St

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 44466 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 44466

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE (No. 4011 Pentherst ST., 15-6-90 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Cornelia Russell Purcell

(a) RESIDENCE NO. 4011 Pentherst ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William T. Purcell

6 DATE OF BIRTH (month, day, and year) Jan 26 1842 Jas

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Alexandria Va

PARENTS

10 NAME OF FATHER John W. Neary

11 BIRTHPLACE OF FATHER (city or town) (State or country) Alexandria Va

12 MAIDEN NAME OF MOTHER Mary Cross

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Alexandria Va

14 Informant Mary Tonnar

(Address) 4011 Pentherst ave

15 Filed MAR 27 1929 C. RAMSAY OGLE, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 26 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan. 26, 1929, to Mar. 26, 1929, that I last saw her alive on Mar 25, 1929 and that death occurred, on the date stated above, at 12.10 a m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) old age

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Thos. C. Blake M. D.

, 19 (Address) 714 Med Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL March 29 1929

20 UNDERTAKER George J Smith — ADDRESS 1532 N Milton Ave

important. See instructions on back of certificates.

Spec.—7-29-28—L. F. S.—500 Bks.

E 44467

HEALTH DEPARTMENT—CITY OF BALTIMORE

31

E 44467

CERTIFICATE OF DEATH

BALTIMORE CITY HOSPITALS

1—PLACE OF DEATH [redacted] REGISTERED NO.

CITY OF BALTIMORE: (No. [redacted] ST., [redacted] WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lucretia Sunderland

(a) RESIDENCE NO. 236 S. Clinton ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: W. Muks

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Lucretia Sheppard

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant (Address): Records of BALTIMORE CITY HOSPITALS

15 Filed MAR 27 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 25, 1929

17 I HEREBY CERTIFY, That I attended deceased from November 30, 1927, to March 25, 1929, that I last saw her alive on March 25, 1929, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis
Pulmonary tuberculosis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no What test confirmed diagnosis? Physical Exam

(Signed) [illegible], M. D.

. 19 (Address) BALTIMORE CITY HOSPITALS

[redacted]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel	Mar 28 1929
20 UNDERTAKER: George J. Smith	ADDRESS 532 Hollins

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44468

CERTIFICATE OF DEATH

57

E 44468

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1215 W Mulberry ST. 18-26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary E Kerr

(a) RESIDENCE NO. 1265 W Mulberry ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	11	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Prince George Co Md

PARENTS

10 NAME OF FATHER Richard Crosby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Moreland

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Ashby Sherbert

(Address) 1215 W Mulberry

15 Filed ..... 19.... HAMPSON JONES, M. D. Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26 1929

17 I HEREBY CERTIFY, That I attended deceased from March 18 1929 to March 26 1929

that I last saw h alive on March 25 1929

and that death occurred, on the date stated above, at 7.40 a m.

The CAUSE OF DEATH* was as follows:

Exhaustion

(duration) mos. 5 ds.

CONTRIBUTORY (Secondary) Diabetes & Chronic Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an aut

What test confirmed diagnosis?

(Signed) Chas L Mortimer M. D.

19 (Address) 5302 Fredrick

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	Mar 28 1929

20 UNDERTAKER Charles H Keehner ADDRESS 153 L Hollins

Spec.—1-10-21—M&T—1500 Blks.

E 44469 HEALTH DEPARTMENT—CITY OF BALTIMORE E 44469

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH Franklin Square Hospital

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Calhoun & Fayette ST. 75-73 WARD)

2-FULL NAME Andrew Hoesl

(a) RESIDENCE NO. 1703 Candler Ave ST. Forest Park WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	white	married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Marie Hecker Hoesl

6 DATE OF BIRTH (month, day, and year) May 12 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	10	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Blacksmith. ✓
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS
10 NAME OF FATHER Adam Hoesl
11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.
12 MAIDEN NAME OF MOTHER Margarite Herrmeier
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Mrs Marie Hecker Hoesl
(Address) 1703 Candler Ave

15 Date MAR 27 1929 Per C. HARRISON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/26 1929

17 I HEREBY CERTIFY, That I attended deceased from 2/23 1929 to Mar. 26 1929, that I last saw him alive on Mar 25 1929, and that death occurred, on the date stated above, at 6.20 a.m.

The CAUSE OF DEATH* was as follows:
Acute Lung pneumonia
Chronic Nephritis
(duration) yrs. 6 mos ? ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) Heller Hemming, M. D.
3/26 1929 (Address) 2000 Hillen Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL Mar. 29, 1929

20 UNDERTAKER Chas. W. Dill. — ADDRESS 3109 Fred'k, Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44470

CERTIFICATE OF DEATH

129

E 44470

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 847 N. Lombard ST. 18-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary M. Simpson

(a) RESIDENCE NO. 847 N. Lombard ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James E. Simpson

6 DATE OF BIRTH (month, day, and year) Mar 1. 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	0	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Joshua Meeks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Martha Schoocks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Lillian E. Petzold

(Address) 1125 W. Hamburg St.

15 Filed C. HARRISON JONES, M. D. Registrar

Per

AR 271529

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 26, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 19. 19 29, to March 26. 19 29, that I last saw h[illegible] alive on March 26. 19 29, and that death occurred, on the date stated above, at 5.45 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Int. Nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Evidence

(Signed) [illegible] M. D.

. 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Mar 29 1929.

20 UNDERTAKER Mrs. Arthur Petzold & Son — ADDRESS 801 N. Fayette

IMPORTANT—Fill in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 44471

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-01 E 44471

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1311 Parrish ST. 15-27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby boy Dorne

(a) RESIDENCE NO. 1311 Parrish ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3-26-29

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
				11 Hours

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Elder Dorne

11 BIRTHPLACE OF FATHER (city or town) (State or country) So. Car.

12 MAIDEN NAME OF MOTHER Flora Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) So. Car.

14 Informant mother

(Address)

15 Filed MAR 27 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-26-29

17 I HEREBY CERTIFY, That I attended deceased from March 26, 1929, to March 26, 1929, that I last saw h[illegible] alive on March 26, 1929 and that death occurred, on the date stated above, at 3 30 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) M. Alexander Norley M. D.

19 (Address) 1516 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 44472 HEALTH DEPARTMENT—CITY OF BALTIMORE E 44472

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1803 Eagle ST. 14-28 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie C. Lane.

(a) RESIDENCE NO. 1803 Eagle. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 32 yrs. 2 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Willard C Lane

6 DATE OF BIRTH (month, day, and year) 1-1-97

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32	2	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John S Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Francis Marlot

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mass.

14 Informant Willard C Lane

Address 1803 Eagle st.

MAR 27 1929

Filed , 19

C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/25 19 29

17 I HEREBY CERTIFY, That I attended deceased from Oct 1 , 19 28 , to Mar 25 , 19 29 ,

that I last saw b alive on Mar 25 , 19 29 ,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) C Chuttle Carl M. D.

(Address) 2105 N Bolton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL 3-28-29

20 UNDERTAKER Geo A Farley

ADDRESS 1500 W Fayette St

IMPORTANT—Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 44473 HEALTH DEPARTMENT—CITY OF BALTIMORE

001 V

E 44473

CERTIFICATE OF DEATH

24

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 741 Mulberry St., 4-7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Florence Jefferson

(a) RESIDENCE NO. 741 Mulberry ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas Jefferson

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Berryville Va.

PARENTS

10 NAME OF FATHER Samuel Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Thomas Jefferson

(Address) 741 A. Mulberry St

15 Filed MAR 27 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 24/29

17

I HEREBY CERTIFY, That I attended deceased from Oct. 11, 1928, to Mar 24, 1929,

that I last saw her alive on Mar 24, 1929

and that death occurred, on the date stated above, at 10.15 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clin. Exam.

(Signed) Mark E. Magruder, M. D.

3/26, 1929 (Address) 1006 Edmondson.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Mar. 29 1929
20 UNDERTAKER Mrs Katie A. Stillwagon	ADDRESS 322 N. Schroeder St

important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44474

CERTIFICATE OF DEATH.

E 44474

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH City of BALTIMORE: (No. Pronounced dead at the South Baltimore General St. Ward)

2-FULL NAME Charles Bougue.(C)

(a) RESIDENCE NO. 942 Leadenhall St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. ---------- How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married.

5a If married, widowed, or divorced HUSBAND of ~~XXXXXX~~ Florence Bougue.(C)

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	48	----------		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer) Empire Construction

(c) Name of employer Company.

9 BIRTHPLACE (city or town)

(State or country) Norfolk, Va.

PARENTS

10 NAME OF FATHER Moses Bougue.(C)

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Virginia.

12 MAIDEN NAME OF MOTHER Louise ---------(C)

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia.

14 Informant Florence Bougue.(C) wife.

(Address) 186 Dolphin St.

15 Filed C. HAMPSON JONES, M. D. Registrar

Per ----------

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25, 1929.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Internal injuries. Crushed about the body by having been caught under rolling logs. Occidental Death.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

(Coroner)

3/27 1929 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs..... mos..... ds. In the state.....yrs..... mos..... ds.

Where was disease contracted, if not at place of death? Yard of Woodall St. March 25, 1929.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL [illegible] Date of Burial 3-28 1929

20 UNDERTAKER [illegible] ADDRESS [illegible]

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

27 1929

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44475

CERTIFICATE OF DEATH

90 E 44475

BALTIMORE CITY HOSPITALS

1—PLACE OF DEATH [redacted]

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST. 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Isabel Turner

(a) RESIDENCE NO. 132 East ..... ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Robert Price

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Missom Blizzard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Records of BALTIMORE CITY HOSPITALS (Address)

15 Filed ....., 19 ..... Registrar C. HAMPSON JONES M.D.

R 2 7 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 21, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 11, 29, 19..... to March 21, 29, 19.....

that I last saw her alive on March 21, 29, 19.....

and that death occurred, on the date stated above, at 6:55 P m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) ..... yrs. 3 mos. ..... ds.

CONTRIBUTORY (Secondary) asthma — Chr. Bron. Cath.

(duration) several years yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) P. M. Finch, M. D.

, 19 ..... (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	3-28 1929
20 UNDERTAKER Daniel Easter	ADDRESS 916 Gay

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44476

CERTIFICATE OF DEATH

E 44476

101-001

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE (No.) BALTIMORE CITY HOSPITALS ST. 5-8 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Leroy Crowell

(a) RESIDENCE NO. 306 N. High St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosa Crowell

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER William Crowell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Jane Walker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant Records of

(Address) Baltimore City Hospitals

15 Filed ....., 19..... C. HAMPSON JONES, M. D.
Per ..... Registrar

R 27 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 19, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 15, 29, to March 19, 29,

that I last saw him alive on March 19, 29

and that death occurred, on the date stated above, at 4 A m.

THE CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & X-Ray

(Signed) R. M. Stock, M. D.

, 19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	3-28-29
20 UNDERTAKER	ADDRESS
Lund Eaton	Balto

IMPORTANT—Write in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44477

CERTIFICATE OF DEATH.

100-201

E 44477

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) 48 Market Space St. 4-6 (Ward)

2-FULL NAME Frank E Biggs

(a) RESIDENCE NO. 48 Market Space St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced. (write the word): Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mattie Biggs

6 DATE OF BIRTH (month, day, and year): 1891

7 AGE: Years 38 Months Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Bolt.

(State or country)

PARENTS

10 NAME OF FATHER: F. D. Biggs

11 BIRTHPLACE OF FATHER (city or town): Md

(State or country)

12 MAIDEN NAME OF MOTHER: Susan Harris

13 BIRTHPLACE OF MOTHER (city or town):

(State or country)

14 Informant: Norman Harris

(Address): 1717 Bond

15 Filed _____, 19____ HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 24 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia

Dont know Primary Cause

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Per dear

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. T. Price M. D.

(Coroner)

March 27, 1929 Address: 1639 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Date of Burial 3/28 1929

20 UNDERTAKER: H. Cook ADDRESS 1217 E Fayette

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

R2 1929

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44478

CERTIFICATE OF DEATH

29 **E 44478**

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 11-25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louella Hempstead

(a) RESIDENCE NO. St James Apts. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of W. McKinley Hempstead

6 DATE OF BIRTH (month, day, and year) Jan 12, 1861

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	68	2	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) North Carolina

PARENTS

10 NAME OF FATHER John B Leonard

11 BIRTHPLACE OF FATHER (City or town)

(State or country) S. C

12 MAIDEN NAME OF MOTHER Mary E Raney

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) S. C

14 Informant W. Kinley Hempstead

(Address) St James Apartments

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/26/29

17 I HEREBY CERTIFY, That I attended deceased from 3/25/29, 19 ..., to 3/26/29, 19 ..., that I last saw her alive on 3/26/29, 19 ..., and that death occurred, on the date stated above, at 6.30 PM m.

The CAUSE OF DEATH* was as follows:

Chronic Disease Nephritis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) ..... yrs. mos. 3 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) J. S. Winstead, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Allen.

Date of Burial 3/29 19 29

20 UNDERTAKER J. M. Cook

ADDRESS 1217 E. Fayette St

MAR 7 1929

NOTE—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44479

CERTIFICATE OF DEATH

188-103

E 44479

1-PLACE OF DEATH

City of Baltimore: (No. St. Joseph Hospital St.) 8-17 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Wendel Houck

(a) RESIDENCE NO. 1837 N. Register St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marian Houck

6 DATE OF BIRTH (month, day, and year) Aug 11/1905

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	23	7	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Chauffer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer C. Oscar Myers

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Leonard Houck

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) "
(State or country)

14 Informant Marian Houck
(Address) 1837 N. Register St

15 Filed MAR 27 1929 16 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 26/29

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock (Hemorrhage) Crushed chest & groin- Accident fell of truck under front wheel

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Belair & Furley Aves

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Cain, M. D.

3/27/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Mar. 29 1929
20 UNDERTAKER	ADDRESS
Thos. E. Miller & Son	2334 Jefferson St.

IF PERSONS OTHER THAN A PHYSICIAN OR UNDERTAKER FILL IN THIS BLANK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44480

CERTIFICATE OF DEATH

E 44480

1—PLACE OF DEATH Union Memorial Hosp REGISTERED NO. 25-15 33

CITY OF BALTIMORE: (No. 33rd + Calvert St. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Thomas Miller

(a) RESIDENCE NO. 110 Hurdcor Brookland St. 2nd WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 18 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 28 1927

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	1	6	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Louisville
(State or country) Kentucky

PARENTS

10 NAME OF FATHER Thomas Miller

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Helen McGowan

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mother
(Address) 110 3rd Ave Brooklyn Md

15 Filed APR 2 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 27 1929

17 I HEREBY CERTIFY, That I attended deceased from March 9, 1929, to March 27, 1929, that I last saw him alive on March 27, 1929, and that death occurred, on the date stated above, at 5:50 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis - generalized
Tbc peritonitis, mediastinitis + pleuritis

(duration) 0 yrs. 6+ mos. ds.

CONTRIBUTORY (Secondary) Tuberculous Meningitis

(duration) yrs. mos. 14+ ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray + Lumb. Puncture

(Signed) Wallace A. Swartzwelder M. D.

19 (Address) Union Memorial Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem	3/29 1929
20 UNDERTAKER Margaret G. Flynn	ADDRESS 22 Light

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44481

CERTIFICATE OF DEATH

× 100-001

E 44481

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1119 E. Eilmot ST., 16-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Norman Custis

(a) RESIDENCE NO. 1119 Eilmot ST., WARD Va
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12/1/1926

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	2	3	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country)

PARENTS

10 NAME OF FATHER Lewis Custis

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Mary Davis

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Mrs Clara
(Address) 1119 Eilmot St

15 Date MAR 27 1929 19 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/27/29

17 I HEREBY CERTIFY, That I attended deceased from 3/26, 19 29, to 3/27, 19 29, that I last saw h.. alive on 3/27, 19 29 and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia
(Primary)

(duration) yrs. mos. 7 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. H. Howard Jones, M. D.

3/27, 19 29 (Address) 912 Eilmot St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	Mar 28 1929

20 UNDERTAKER Thomas E. Kelson.

ADDRESS 1303 Pressman St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44482

CERTIFICATE OF DEATH.

13 E 44482

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No. ~~300 S. Monroe~~ Monument St. ST. 70-28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm. Harry Goedeny

(a) RESIDENCE No. 300 S. Monroe ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND (of) (or) WIFE of Minnie Goldberg

6 DATE OF BIRTH (month, day, and year) 2-15-1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	45	~~7~~ 0	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocery

(b) General nature of industry, business, or establishment in which employed (or employer) 034

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Jacob Goldberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Hinkin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Mrs J. Hogan

(Address) 300 S. Monroe St

15 Filed 3 28 1929 H. [illegible], M. D. Registrar

MAR 28 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28 1929

17

I HEREBY CERTIFY, That I attended deceased from March 18, 1929, to March 28, 1929, that I last saw him alive on March 28, 1929, and that death occurred, on the date stated above, at 1:20 A m.

The CAUSE OF DEATH* was as follows:

Hydropyonephrosis, (Left)

(duration) yrs. 1? mos ds.

CONTRIBUTORY Uremia (Secondary)

(duration) yrs. mos. 3? ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 1927 Rt Nephrectomy 1929 Tht

Was there an autopsy? No

What test confirmed diagnosis? Clinical History, Lab, Cystoscopy

(Signed) C. Hyman, M. D.

3/28 19 29 (Address) Sinai Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mash Wood — DATE OF BURIAL 3/28 1929

20 UNDERTAKER Jack Lewis 1739 E Balto St — ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44483
1—PLACE OF DEATH

CERTIFICATE OF DEATH

24-001 E 44483

REGISTERED NO.

CITY OF BALTIMORE: (No. 1602 N. Bethel st. ST. 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ellen L Blondell.

(a) RESIDENCE NO. 1602 N. Bethel st. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed, or Divorced~~ (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Late John Blondell.

6 DATE OF BIRTH (month, day, and year): 1860

7 AGE — Years: 68 | Months: | Days: | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: John S. Lynch.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Ellen Finn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland.

14 Informant: John A. Blondell.
*(Address): 1602 N. Bethel st

15 Filed MAR 29 1929 19 C. HERBERT JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/26/29

17 I HEREBY CERTIFY, That I attended deceased from 3/24/29, 19, to 3/26/29, 19, that I last saw her alive on 3/26/29, 19, and that death occurred, on the date stated above, at 7.30 P.m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage from arteriosclerosis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of None

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. Lee Magness, M. D.

3/27, 1929 (Address) 1806 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cemetery Hartford Rd

DATE OF BURIAL: March 29 1929

20 UNDERTAKER: George F. Ruth

ADDRESS: 1735 Hoffman av

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

153

E 44484

CERTIFICATE OF DEATH

REGISTERED No. E 44484

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1812 Harford ST., 9th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Melvin O. Geoghegan

(a) RESIDENCE NO. 1812 Harford av ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed, or Divorced~~, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 23 1925

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	9.	3	

8 OCCUPATION OF DECEASED —

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Harry Geoghegan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Marie H. Tuckman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Harry A. Geoghegan

(Address) 1812 Harford av

15 MAR 28 1929 C. HARRISON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26 1929

17 I HEREBY CERTIFY, That I attended deceased from December 10, 1928, to March 26, 1929, that I last saw him alive on March 26, 1929 and that death occurred, on the date stated above, at 555 P. M.

The CAUSE OF DEATH* was as follows:

Abscess of right thigh.
Secondary Cancrum oris

(duration) yrs. 3 mos. 17 ds.

CONTRIBUTORY (Secondary) Cancrum oris duration

(duration) yrs. mos. 3 da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) Albert Oppenheimer, M. D.

3/27, 19 (Address) Albert Oppenheimer

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Paul Cemty.	March 29 1929,
20 UNDERTAKER	**ADDRESS**
Geo. L. Buck	1735 Harford av

Cor.—12-9-25—A Co.—200 Bks.

E 44485 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91-001 E 44485

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1750 E North Ave St., 9-47 Ward)

2-FULL NAME Henry Roth

(a) RESIDENCE NO 3626 Edmondson Road St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. 5 mos. 17 ds. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of ~~WIFE of~~ Katherine Roth

6 DATE OF BIRTH (month, day and year) October 1 - 1858

7 AGE — Years: 70 — Months: 5 — Days: 17 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Merchant

(b) General nature of industry, business, or establishment in which employed (or employer): Grocery

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Christian Roth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant C. Walter Roth

(Address) 3626 Edmondson Road

15 Filed....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Aortic Aneurism

(duration) .....yrs. .....mos. .....ds.

(Signed) J. H. Potter M. D.

(Coroner)

3/26/29 (Address) 506 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — Date of Burial: Mar 29 1929

20 UNDERTAKER: Wm. J. Tschiesche Sons — ADDRESS: 1 Pa Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAR 28 1929

Spec–12-23-21–E.B.R.S.–400 Eks.

E 44486 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 44486

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 421 Winston Ln St. 27-43 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. August R. Tischinger

(a) Residence No. 421 Winston Ln St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced (write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mabel Hillman Tischinger

6-DATE OF BIRTH (month, day and year) July 3-1880

7-AGE. 48 yrs. 8 mos. 23 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Florist

(b) General nature of industry, business, or establishment in which employed (or employer). Self 045

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Pikesville, Md

PARENTS.

10-NAME OF FATHER. Julius Tischinger

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Jane Smart

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Ireland

11-

(Informant) Mrs. M. A. Tischinger

(Address) 421 Winston Ave

15-

Filed MAR 28 1929 WILLIAM JONES, Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 26, 1929

17- I HEREBY CERTIFY, That I attended deceased from Feb 19, 1927 to March 26, 1929.

that I last saw h. alive on March 25, 1929.

and that death occurred, on the date stated above, at 4:15 P. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Chr. Lat. Nephritis, Chr. Myocarditis

Chr. Pulmonary Tuberculosis 5 yrs

(Duration) yrs. 34 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(Duration) yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) D. W. Bishop M. D.

Mch 27, 1929 (Address) 501 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Govans Presbyterian	Mar 28, 1929
20-UNDERTAKER	ADDRESS
J. Fichner & Sons	Govans

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44487

CERTIFICATE OF DEATH.

15-002

E 44487

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 4035 Fairfax Ave. Ward 15-63)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eugene Raynor Brown

(a) RESIDENCE No. 3900 Norfolk Ave. St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 24 '29

7 AGE	Years	Months	Days	IF LESS than 1 day 6 hrs. or ..... min.
			2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) md

PARENTS

10 NAME OF FATHER Harold R Brown

11 BIRTHPLACE OF FATHER (city or town) Balto

(State or country) md

12 MAIDEN NAME OF MOTHER Estell L Tiller

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) md

14 Informant Harold R Brown

(Address) 3900 Norfolk Ave

Filed MAR 26 1929, 19 CHAMPION JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 27 1929

17

I HEREBY CERTIFY, That I attended deceased from Mar 24, 1929, to Mar 27, 1929, that I last saw him alive on Mar 26, 1929, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Congenital Debility

Foramen Ovale Not Closed

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. L. Flair M. D.

3/27, 1929 (Address) 2704 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem Date of Burial Mar 27 1929

20 UNDERTAKER Wm J Tucker & Son ADDRESS N. Pa

For method of securing signatures, AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 44488

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44 E 44488

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 111 East west ST. 24-33 WARD)

2—FULL NAME Ludwig Neussiger

(a) RESIDENCE NO. 111 East west ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Emilie Neussiger

6 DATE OF BIRTH (month, day, and year) Jan 30 1869

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
60	1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sheet Metal

(b) General nature of industry, business, or establishment in which employed (or employer) Worker

(c) Name of employer For self

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER John Neussiger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Emma Voget

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Emilie Neussiger
(Address) 111 E West St

15 Filed APR 26 1929, 19 C. HAMPSON JONES, M. D.
Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-27-29

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1929 to March 27, 1929 that I last saw h[illegible] alive on March 27, 1929 and that death occurred, on the date stated above, at 9a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) Dont Know

CONTRIBUTORY (Secondary) Extensive abdominal metastasis (duration) Dont Know

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of March 14, 1929

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam. X-ray Exam. Exploratory abdominal operation

(Signed) Edward Norris M. D.

3-27-1929 (Address) 107 East west St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 3-30-1929

20 UNDERTAKER Ernest B Hartz 115 E West St

ADDRESS

Spec.—2-29-28—L. F. S.—500 Bks.

E 44489

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

33

E 44489

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) Baltimore City Hospitals ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emma Lewis

(a) RESIDENCE NO. 2032 McCulloh st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1910

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	19			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waitress

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Eulah Laws

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records

(Address)

15 Filed, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 14, 1929 to March 25, 1929, that I last saw her alive on March 25, 1929 and that death occurred, on the date stated above, at 7 p. m.

The CAUSE OF DEATH* was as follows:

Generalized peritonitis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical and autopsy

(Signed) Henry Schmidt, M. D.

3-27, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem

DATE OF BURIAL 3/28/29

20 UNDERTAKER Samuel Abersly Sr

ADDRESS 537 B. Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 44490

31

E 44490

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2235 W. Baltimore St. ST., 20-69 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME M. Joseph Healy

(a) RESIDENCE NO. 2235 W. Baltimore St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 21, 1898

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	5	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Michael J. Healy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen Ruddy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Miss Mary Healy

(Address) 2235 W. Baltimore St.

15 Filed 19 C. HAMPSON JONES, M. D.

Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26, 1929

17 I HEREBY CERTIFY, That I attended deceased from January 6th 29, to March 26th 29, that I last saw h in alive on March 26th, 29 and that death occurred, on the date stated above, at 7.35 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

CONTRIBUTORY (Secondary) Cardiac asthenia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? (duration) yrs. mos. ds.

Did an operation precede death? Date of

Was there an autopsy? What test confirmed diagnosis? Clinical

(Signed) Edw Mendelsohn M. D.

3/27 19 29 (Address) 24 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL Mar 30th 1929

20 UNDERTAKER J. J. Cowen & Son

ADDRESS 501 Holliday St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 44491 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

109-002

E 44491

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1253 (Street) Williams St. (WARD) 24-33

2-FULL NAME Lillian R. Phillips

(a) RESIDENCE NO. 1253 (Usual place of abode) Williams ST., WARD

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: W. W.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Nov. 10, 1921

7 AGE: Years 7 Months 4 Days 15 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Walter W. Phillips

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Lillian J. Rudolph

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Mrs Lillian Phillips (Address) 1263 Williams St.

15 Filed MAR 28 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 25 1929

17 I HEREBY CERTIFY, That I attended deceased from March 20, 1929, to March 25, 1929, that I last saw h[illegible] alive on March 25, 1929, and that death occurred, on the date stated above, at 7. P. m.

The CAUSE OF DEATH* was as follows:

Septic Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C. Mahler M. D.

(Address) 1279 Fillmore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery DATE OF BURIAL: Mar 29 1929

20 UNDERTAKER: F. A. Kirbuse & Son ADDRESS: 703 Hanover St.

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 44492 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. E 44492

1-PLACE OF DEATH 2019 Fleet St.

CITY OF BALTIMORE: (No. 2019 ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes Gibmeyer

(a) RESIDENCE NO. 2019 Fleet St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if of foreign birth? 57 yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) widow

5a If married, widowed, or divorced (or) ~~HUSBAND of~~ WIFE of John F Gibmeyer

6 DATE OF BIRTH (month, day, and year) Dec. 17, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Joseph Schmeltz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Salomo

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant (Address) Josephine Gibmeyer 2019 Fleet St

Filed MAR 28 1929 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25 1929

17

I HEREBY CERTIFY, That I attended deceased from March 12 1929 to March 25 1929

that I last saw her alive on March 25 1929

and that death occurred, on the date stated above, at 6 25 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension, nephritis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) L C Sobieski M. D.

March 25 1929 (Address) 417 N. Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem. DATE OF BURIAL: March 29 1929

20 UNDERTAKER: Lacy & Jenkins Inc. ADDRESS: 40 S. Carey St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44493

CERTIFICATE OF DEATH.

111-001

E 44493

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6718 Bessemer Ave ST., 26-37 WARD)

2-FULL NAME John Daniel Schaech

(a) RESIDENCE NO. 6718 Bessemer Ave ST., 26 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Agatha H. Schaech

6 DATE OF BIRTH (month, day, and year) May 1, 1874

7 AGE	Years	Months	Days 24	If LESS than 1 day, hrs. or min.
54	55	10	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Moulder

(b) General nature of industry, business, or establishment in which employed (or employer) Iron 047

(c) Name of employer Kennedy Iron Foundry

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Francis Schaech

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bavaria Germany

12 MAIDEN NAME OF MOTHER Mary E. Schneider

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bavaria Germany

14 Informant Wife - Agatha H. Schaech

(Address) 6718 Bessemer Ave

15 Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 25, 1929

17 I HEREBY CERTIFY, That I attended deceased from March, 1926, to Mar. 25, 1929, that I last saw him alive on Mar. 25, 1929 and that death occurred, on the date stated above, at 10.25 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) 1 yrs. mos 2 ds.

CONTRIBUTORY (Secondary): Gastric Ulcer - Hemorrhage

Arthritis spinal (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Typical Evidence

(Signed) Wm B. Sybert, M. D.

, 19 (Address) 2802 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Mch 27 1929
20 UNDERTAKER	ADDRESS
Lilly & Sons Inc.	40 S. Wash St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAR 26 1929

H. ADAMS JONES, M.D.

Spec.-7-17-26—A Co.—200 Bks.

E 44494

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 44494

REGISTERED NO.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

City of BALTIMORE: (No.) Mercy Hospital St. (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bruno H. Hoffman

(a) RESIDENCE NO. 1007 Baylis St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nettie J. Hoffman

6 DATE OF BIRTH (month, day, and year) Nov. 17-1874

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	54	4	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Oiler

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER George Hoffman

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) not known

14 Informant Nettie J. Hoffman

(Address) 1007 S. Baylis St

Filed MAR 28 1929 HAMPSON JONES, M. D. Registrar

Det. Hill

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/25/29

17 I HEREBY CERTIFY, That I attended deceased from 9/1/24, 19..., to 3/25/29, 19..., that I last saw him alive on 3/25/29, 19..., and that death occurred, on the date stated above, at 11:25 a.m.

The CAUSE OF DEATH* was as follows:

Virginia Hernia

(duration) ... yrs. ... mos. 15 ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism

(duration) Sudden yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? yes Date of 3/19/29

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Jos. Wintrobe M. D.

. 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cemetery — Date of Burial March 29th 29

20 UNDERTAKER George W. Zirkler — ADDRESS 1737 E. Eager

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44495

90

CERTIFICATE OF DEATH

E 44495

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1713 Aliceanna St ST., 2-4 WARD)

2—FULL NAME John Chrzanowski

(a) RESIDENCE NO. 1713 Aliceanna Street ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer) O+O

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mrs. [illegible]

(Address) 1713 Aliceanna Street

15 Filed MAR 28 1929

16 [illegible] C. Hanson JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 27-29

17 I HEREBY CERTIFY, That I attended deceased from June 3, 1928, to March 27, 1929, that I last saw h[illegible] alive on March 27, 1929 and that death occurred, on the date stated above, at 2:30 p. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency (duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac asthma (duration) — yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? P. S. & S.

(Signed) John V. Szczucki, M. D.

(Address) 1738 Eastern ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St, Stanislaus Cemetery	April 2 1929
20 UNDERTAKER George A Weber 705	ADDRESS S Ann st

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44496

100-001

E 44496

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) 117 N. Mount St., (WARD) 14-27

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emma Burroughs

(a) RESIDENCE NO. 117 N Mount ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Burroughs

6 DATE OF BIRTH (month, day, and year) Unknown 1899

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	30	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 0/0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lonaconing Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant John L Burroughs

(Address) 117 N Mount St.

15 Filed ... 19 ... C. HAMPSON JONES, M. D.

Per ... Registrar

MAR 28 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 25/29

17

I HEREBY CERTIFY, That I attended deceased from Mar 23, 1929, to Mar 25, 1929,

that I last saw ... alive on Mar 25, 1929

and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Lobular Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) ~

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? ~ Date of ~

Was there an autopsy? ~

What test confirmed diagnosis? ~

(Signed) H. F. Hatcher, M. D.

3/27, 1929 (Address) 1115 E Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lonaconing Md.

DATE OF BURIAL Mar 28, 1929

20 UNDERTAKER Mrs. R. G. Elliott

ADDRESS 1717 Eastlandon

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 44497

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129-E 44497

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1819 Harford ave ST., 9-46 WARD)

2—FULL NAME Sallie J Link

(a) RESIDENCE NO. 1819 Harford ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of John Link

6 DATE OF BIRTH (month, day, and year) Feb 28-1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45	5	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer 037

9 BIRTHPLACE (city or town) (State or country) Harford Co Maryland

PARENTS

10 NAME OF FATHER Joseph L Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co Maryland

12 MAIDEN NAME OF MOTHER Hannah J Curry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harford Co Maryland

14 Informant John Link

(Address) 1819 N Harford Ave

Filed MAR 28 1929, 19 C. JAMESON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-26-29

17 I HEREBY CERTIFY, That I attended deceased from 3/10, 1929, to 3/26, 1929, that I last saw her alive on 3/26, 1929, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Aortic Regurgitation & Chronic Interstitial Nephritis

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) David Miller, M. D.

3/28, 1929 (Address) 1500 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	March 29 1929
20 UNDERTAKER Henry Lutz	ADDRESS 1203 N Broadway

IMPORTANT.—Every question on this certificate should be carefully answered. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.--10-10-29—A Co.—100 Bks.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

44498

CERTIFICATE OF DEATH

179

E 44498

REGISTERED NO.

1-PLACE OF DEATH

City of Baltimore: (No. St. Joseph Hospital St., 9-46 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fannie Manyer

(a) RESIDENCE NO. 1205 Darley Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of William Manyer

6 DATE OF BIRTH (month, day, and year) June 26 1855

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	73	9	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Germany

PARENTS

10 NAME OF FATHER Christian Langguth

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Marguerite Sell

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Bertha Hokemyer
(Address) 3900 Woodlea Ave

15 Filed MAR 28 1929 William H. Jones, M. D., Registrar
by [illegible]

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 27/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Toxemia- 3rd degree burns body, face & arms. Clothes caught fire while hanging curtain over kitchen stove

Mch 10/29 (Accidental) (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage old gastric ulcer (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? Partial

What test confirmed diagnosis?

(Signed) J. S. Bloom M. D.

(Address) 516 E. Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon PK

DATE OF BURIAL 3/29/1929

20 UNDERTAKER Philip Herwig

ADDRESS 2016 Orleans St.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44499

CERTIFICATE OF DEATH

E 44499

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 505 N. Washington St., (WARD) 7-9

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth A. White

(a) RESIDENCE NO. 505 N. Washington ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 79 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alexander White

6 DATE OF BIRTH (month, day, and year) July 15/1849

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
79	8	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER William Gardner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs John Monath

(Address) 505 N. Washington St

15 Filed ..... 19 ..... HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26/29

17 I HEREBY CERTIFY, That I attended deceased from Jan 18, 19 29, to March 26, 19 29, that I last saw h[illegible] alive on March 25, 19 29 and that death occurred, on the date stated above, at 3 30 A. m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward [illegible], M. D.

3/26/19 29 (Address) 413 N. Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dallo Cem

DATE OF BURIAL 3/28/29

20 UNDERTAKER Philip Henrig

ADDRESS 20 [illegible] Orleans St

MAR 28 1929

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44500

E 44500

CERTIFICATE OF DEATH

REGISTERED NO. 197

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Johns Hopkins Hospital St., 3-4 Ward)

2-FULL NAME Horace Ponton

(a) RESIDENCE NO. 304 S. Spring St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	black	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 2/1897

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	31	5	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 640
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Enfield, N.C.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) "
(State or country)

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) "
(State or country)

14 Informant Marie Ponton (sister)
(Address) Suffolk, Va.

15 Filed MAR 26 1929 19 HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 23/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) Inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Sepsis due to bullett wound left Shoulder (Mar 13/29) Homicide

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? Yes. By Dr. Maldeis

What test confirmed diagnosis?

(Signed) [illegible], M. D.

3/20/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
National Cemetery	3/28 1929
20 UNDERTAKER George J. Ruth	ADDRESS 1735 Harford Av

GEN. B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-11—M. & I.—2000 lbs.

E 44501 HEALTH DEPT.—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 44501

REGISTERED No. C

1-PLACE OF DEATH Mercy Sanitarium Asylum

CITY OF BALTIMORE: (No. Fishmarket Road St. 28 WARD 7)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary B. O. Black

(Residence in Baltimore: No. Ethel Francis Road St.: ...yrs. ...mos. ...ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Widowed

6-DATE OF BIRTH, July (Month) 28 (Day), 1839 (Year)

7-AGE, 87 yrs. 7 mos. 27 ds. If LESS than 1 day, ...hrs. or ...min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Laundry
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Cumberland Md

PARENTS.

10-NAME OF FATHER, Hanson B. Pagenan

11-BIRTHPLACE OF FATHER (State or Country), Cumberland Md

12-MAIDEN NAME OF MOTHER Mary E. Shuler

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) D. D. S. T. Gundreys

(Address) Frederick Md

15- Filed MAR 28 1929, 19..., HARRISON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, March (Month) 27 (Day), 1929 (Year)

17- I HEREBY CERTIFY, That I attended deceased from Oct 1 1927, to March 27 1929, that I saw h.. alive on March 27 1929, and that death occurred, on the date stated above, at 7.10 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) ...yrs. ...mos. 1/2 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(Duration) many yrs. ...mos. ...ds.

(Signed) H. Jones M. D.

March 27 1929 (Address) Mercy Hospital

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 1 yrs. 2 mos. ...ds. In the State 1 yrs. 2 mos. ...ds.

Where was disease contracted, if not at place of death? Home Cherry Tree W Va.

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Washington DC — DATE OF BURIAL, March ..., 1929

20-UNDERTAKER John C. Mitchell & Sons — ADDRESS 1900 Eutaw Place

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 lks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 44502 ✓ 101-001 E 44502

E 44502
1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 512 N. Stricker ST. 19-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Olivera Daniels

(a) RESIDENCE NO. 512 N. Stricker ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. 10 mos. 23 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Child

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 4, 1926

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
2	10	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) n/k

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Illegitimate

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Ester Daniels

13 BIRTHPLACE OF MOTHER (city or town) Rocky Mt.
(State or country) N.C.

14
Informant Lena Mills
(Address) 512 N. StrickerSt.

15
Filed Mar 28 1929 G. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 27, 1929

17
I HEREBY CERTIFY, That I attended deceased from Mar. 25, 1929 to Mar. 27 1929,
that I last saw her alive on Mar. 27 1929
and that death occurred, on the date stated above, at 6 p m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical exam.

(Signed) Walter J. Jackson, M. D.

19 (Address) 1631 W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Auburn	3-28 1929
20 UNDERTAKER	ADDRESS
Joseph Oslively	409 N. Mount St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

159-00

CERTIFICATE OF DEATH

E 44503

REGISTERED NO. E 44503

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 630 Bruce St ST. 16-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Boy Crawford

(a) RESIDENCE NO. 630 Bruce St ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	black	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 21, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) 630 Bruce St
(State or country)

PARENTS

10 NAME OF FATHER William Crawford

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Gladys Thomas

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Mother
(Address)

MAR 26 1929 CLYDE V. JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 24, 1929, to March 25, 1929, that I last saw him alive on March 25, 1929 and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Patent foramen ovale
Enlarged Thymus Gland
(Status lymphaticus)

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) M. Alexander Hovey, M. D.

, 19 (Address) 1516 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

UNIVERSITY OF MARYLAND
Commissioner Health.
MAR 27 1929

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—560 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44504

CERTIFICATE OF DEATH

44

E 44504

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 532 E. North Ave. ST.) (G-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna Elizabeth Devereaux

(a) RESIDENCE NO. 532 E North Ave ST., WARD 9th

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 18, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Kingsville Balto. Co. Md.

PARENTS

10 NAME OF FATHER James T. Devereaux

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Eliz Crane

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Katherine Welch

(Address) 532 E. North Ave.

15 Filed MAR 28 1929 HARRISON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 27. 1929

17 I HEREBY CERTIFY, That I attended deceased from January 29, 1929, to March 26, 1929

that I last saw h.. alive on March 26th 1929

and that death occurred, on the date stated above, at 3 20 a. m.

The CAUSE OF DEATH* was as follows:

Gastro-Intestinal Carcinoma.

Indefinite (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edward E Hooker, M. D.

, 19 (Address) 530 E. North Avenue.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Com.	3 29 1929
20 UNDERTAKER	ADDRESS
C. Vernon Lemmon	501 E. 22 St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 44505

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

8K~E 44505

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 3048 Edmondson St. 16-20 (Ward)

2-FULL NAME Freeman F. Mayor

(a) RESIDENCE NO. 3048 Edmondson St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Mal

4 Color or Race: White

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ida.

6 DATE OF BIRTH (month, day, and year): May 28-1884

7 AGE: Years 44 | Months 9 | Days 29. | IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Carpenter 015
(b) General nature of industry, business, or establishment in which employed (or employer): Contractor
(c) Name of employer

9 BIRTHPLACE (city or town): N. J.
(State or country)

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town): N J
(State or country)

12 MAIDEN NAME OF MOTHER: Unknown.

13 BIRTHPLACE OF MOTHER (city or town): N J
(State or country)

14 Informant: Ida Mayor
(Address): 3048 Edmondson

15 Filed ..... 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): May 27th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest,
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Neuritis.

(duration) ... yrs. 6 mos. ... ds.

CONTRIBUTORY (Secondary) Acute Endocarditis

(duration) ... yrs. One mos. ... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. G. Leuch, M. D.

(Address) May 27th 1929 Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn

DATE OF BURIAL: 3/30 1929

20 UNDERTAKER: Williams Co

ADDRESS: 917 Park Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAR 26 1929

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44506

CERTIFICATE OF DEATH

65-001

E 44506

1—PLACE OF DEATH

REGISTERED NO. 15-61

CITY OF BALTIMORE: (No.) 2413 Powhatan St. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary C. McConville

(a) RESIDENCE NO. 2413 Powhatan Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: James R. Powhatan

6 DATE OF BIRTH (month, day, and year): Sept 19, 1863

7 AGE: Years 65 | Months 6 | Days 8 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer: Home

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Thomas Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Elizabeth Williamson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: James C. Williams

(Address) 2413 Powhatan

15 Filed MAR 28 1929 H. JULIAN JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 27, 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 20, 1928 to March 27, 1929, that I last saw her alive on March 26, 1929 and that death occurred, on the date stated above, at 1:20 a.m.

The CAUSE OF DEATH* was as follows:

1 Hypostatic Pneumonia

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) Jno. Lenker, M. D.

3-28, 1929 (Address) 701 Mechanics Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: 3/28 1929

20 UNDERTAKER: Wilson Cook

ADDRESS: 1217 E. Fayette St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44507

CERTIFICATE OF DEATH

E 44507

REGISTERED NO.

1—PLACE OF DEATH St Joseph Hospital

CITY OF BALTIMORE: (No. Caroline ST., 17-31 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William J. Campagne

(a) RESIDENCE NO. 343 West 2 ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosey Campaigne

6 DATE OF BIRTH (month, day, and year) Feb 16, 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	1	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Moulder

(b) General nature of industry, business, or establishment in which employed (or employer) Iron Foundry

(c) Name of employer E. R. Zimmick

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Richd Campaigne

11 BIRTHPLACE OF FATHER (city or town) Prussia

(State or country)

12 MAIDEN NAME OF MOTHER Mary Norfield

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Md.

14 Informant Rosey Campaigne

(Address) 343 W 2 St

Filed MAR 28 1929 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 27. 1929

17 I HEREBY CERTIFY, That I attended deceased from 3-23-29, 19..., to 3-27-29, 19..., that I last saw h.. alive on 3-27-29, 19... and that death occurred, on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:

Cancer of Bladder

Not Known (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestinal Malaise & Obstruction (duration) yrs. 2 mos. 24 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 3-8-29

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) W B Hendrix, M. D.

27, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 3/29 19 29

20 UNDERTAKER W. M. Cook

ADDRESS 1211 E Fayette St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

KURG

E 44508 HEALTH DEPARTMENT—CITY OF BALTIMORE 44 E 44508

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Baltimore City (ST.) 2616 39 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Kurg

(a) RESIDENCE NO. 39 Heyleland ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 18 Dec Month

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
56	57	3	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Philip

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Mary Gemmer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Minnie Jordan

(Address) 3903 Fairmount av

15 Filed MAR 28 1929 C. HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/27/29

17 I HEREBY CERTIFY, That I attended deceased from 9/22, 19 28, to 3/27, 19 29, that I last saw h— alive on 3/27, 19 29, and that death occurred, on the date stated above, at 10 30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Esophagus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unk

Did an operation precede death? Yes Date of 8/29/28

Was there an autopsy? No

What test confirmed diagnosis? Clinical Evid

(Signed) H. M. Hitch, M. D.

, 19 (Address) Balto City Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Pauls Cem	Mar 31 '29
20 UNDERTAKER	ADDRESS
Martin W & Duffield	812 Cathedral St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—2-29-28—I. F. S.—500 Bks.

E 44509

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44509

CERTIFICATE OF DEATH

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS [redacted] REGISTERED NO. 38

CITY OF BALTIMORE: (No. 4-25 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Paul Mack

(a) RESIDENCE NO. 237 Pine ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	31			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) O.K.D.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) British West Indes

PARENTS

10 NAME OF FATHER Zino Mack

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Priscilla ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New Orleans

14 Informant Records of BALTIMORE CITY HOSPITALS (Address) [redacted]

15 Filed ....., 19 L. HAMPSON JONES, M. Registrar

3123 RFH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 24, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 12, 29, 19..., to March 24, 29, 19...,

that I last saw him alive on March 24, 19 29

and that death occurred, on the date stated above, at 11:50 P.m.

The CAUSE OF DEATH* was as follows:

Syphilis of aorta with aortic insufficiency

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. myocardial degeneration (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical + Laboratory

(Signed) H. McStat, M. D.

BALTIMORE CITY HOSPITALS

*State the [redacted] violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cem. DATE OF BURIAL Apr 2 1929

UNDERTAKER J. Heruser Bro. 1109 E Baltimore

ACCEPTED MAR 28 1929

Commissioner of Health

MAR 29 1929

Registrar

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 44510

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44510

CERTIFICATE OF DEATH

31

1—PLACE OF DEATH Baltimore City Hospitals — REGISTERED NO.

CITY OF BALTIMORE: (No. ____ ST., 2-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Homer White

(a) RESIDENCE NO. 1702 Thames st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
36	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook 121

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Kentucky

PARENTS

10 NAME OF FATHER George White

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kentucky

12 MAIDEN NAME OF MOTHER Alice Bash

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kentucky

14 Informant Hospital Records

(Address)

15 Filed MAR 28 1929, 19 C. HAMPSON JONES, M. D. Registrar

3121 RCH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25, 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb. 28, 1929, to March 25, 1929, that I last saw him alive on March 25, 1929 and that death occurred, on the date stated above, at 2.30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis Clinical and lab.

(Signed) Henry Smith, M. D.

3-25, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

MAR 28 1929

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

AR 28 1929

Spec.—2-29-28—L. F. S.—500 Bks.

E 44511 HEALTH DEPARTMENT—CITY OF BALTIMORE E 44511

CERTIFICATE OF DEATH

31

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Baltimore City Hospitals ST. (2B4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harvey Brockenberry

(a) RESIDENCE NO. 254 S. Spring st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dishwasher

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Paul Brockenberry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Victoria White

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records

(Address)

15 Filed MAR 28 1929 C. HAMPSON JONES, M. D. Registrar

3125 dew

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 25, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 26, 1928 to March 25, 1929 that I last saw h im alive on March 25, 1929 and that death occurred, on the date stated above, at 5.45 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical and lab.

(Signed) Henry C. Smith M. D.

3-25, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

MAR 24 1929

Commissioner Health.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

E 44512

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44512

CERTIFICATE OF DEATH

+ 118-00

1-PLACE OF DEATH Md. Gen. Hosp. REGISTERED NO.

City of BALTIMORE: (No. Balto Md. St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Drucilla Whitcomb

(a) RESIDENCE NO. Owings Mills, Md St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Harvey Whitcomb

6 DATE OF BIRTH (month, day, and year): May 3-1883

7 AGE: 45 Years 9 Months 25 Days

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md.

PARENTS

10 NAME OF FATHER: George Wm. Brown

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Almira Drucilla Norfolk

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Balto Md

14 Informant (Address): Hope Mass

15 [illegible] 19 C. HAMPSON JONES, M. D. Registrar

Mar 28 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-28-1929

17 I HEREBY CERTIFY, That I attended deceased from 3-27 —, 1929, to 3-28 —, 1929, that I last saw h alive on 3-28 —, 1929, and that death occurred, on the date stated above, at 2:14 P m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Intestinal Paralysis

(duration) yrs. mos. 15 hrs. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? Yes Date of 3-27-29

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

19 , 19 (Address)

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury M E Cemetery — Date of Burial: Mar 31 1929

20 UNDERTAKER Restaurant — ADDRESS J. F. Edwards Restaurateurs

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 44513

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44513

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 9 York Court ST., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elsie Rathbone Moore

(a) RESIDENCE NO. 9 York Court ST., 12 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. ? mos. ? ds. How long in U. S., if foreign birth 40 yrs. 10 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Moore

6 DATE OF BIRTH (month, day, and year) May 27 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	10	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) Parkersburg
(State or country) W. Va.

PARENTS

10 NAME OF FATHER Camden Rathbone

11 BIRTHPLACE OF FATHER (city or town) Parkersburg
(State or country) W. Va.

12 MAIDEN NAME OF MOTHER Mary B. Blackford

13 BIRTHPLACE OF MOTHER (city or town) Parkersburg
(State or country) W. Va.

14 Informant Wm Jno Moore (Husband)
(Address) 9 York Court City.

15 Filed ..... 19 ..... Registrar

CHAMPSON JONES

MAR 28 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 27-1929

17 I HEREBY CERTIFY, That I attended deceased from March 27 1929 to March 28 1929 that I last saw her alive on March 28th 1929 and that death occurred, on the date stated above, at 4:30A m.

The CAUSE OF DEATH* was as follows:

Streptococcus hemolyticus infection - fulminating type

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypotension

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Nathaniel M Beck M. D.

. 19 (Address) 105 E. 23rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Mar 30 1929.
20 UNDERTAKER	ADDRESS
Edward Mowen & Son	Bald.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44514

CERTIFICATE OF DEATH

90 E 44514

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hospitals 69 ST., (E. B.) WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Andrew Cudlin

(a) RESIDENCE NO. 1935 Orleans st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
52	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records

(Address)

15 Filed C. HAMPSON JONES, M. D. Registrar

MAR 28 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28, 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec. 30 27, to March 28 29,

that I last saw him alive on March 28 29

and that death occurred, on the date stated above, at 12.05 a. m.

The CAUSE OF DEATH* was as follows:

Acute cardiac dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical and autopsy

(Signed) Howard Smith, M. D.

3-28. 19 29 Address Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Hill	Mar 30 19 29
20 UNDERTAKER	ADDRESS
Frank Brackston	190 Eutaw

IMPORTANT—Answers to questions must be full and complete. ALL blanks must be filled. ALL items should be stated EXACTLY. PHYSICIANS should use DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44515

CERTIFICATE OF DEATH

154-002

E 44515

REGISTERED NO.

I—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3314 Kenwick Rd ST. 43-5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Uldine L. Huff.

(a) RESIDENCE NO. 3314 Kenwick Road ST.. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. 4 How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single.

3a If married, widowed, or divorced HUSBAND of (or) WIFE of —.

6 DATE OF BIRTH (month, day, and year) March 24, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			4	

8 OCCUPATION OF DEECASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md.

PARENTS

10 NAME OF FATHER Marion Huff

11 BIRTHPLACE OF FATHER (city or town) (State or country) md.

12 MAIDEN NAME OF MOTHER Evelyn Allen.

13 BIRTHPLACE OF MOTHER (city or town) md. (State or country)

14 Informant Marion Huff.

(Address) 3314 Kenwick Road

15 Filed MAR 28 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28/29.

17 I HEREBY CERTIFY, That I attended deceased from 3-23, 19 27, to 3-28, 19 29

that I last saw h alive on 3-28, 19 29

and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Patent Ductus Arter

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Premature Infant

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) C. F. Campbell M.D.

3/28/29, 19 (Address) 3701 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary Hampden	March 29, 19 29.
20 UNDERTAKER	ADDRESS
Chenowith Inc	34 E Chase St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 44516

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 44516

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 650 Bartlett Ave ST., 9-4a WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jinnie Norris Hubbard.

(a) RESIDENCE NO. 650 Bartlett Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed.

a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Late Walter Hubbard.

6 DATE OF BIRTH (month, day, and year) March 4 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68		24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Isac Horney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Norris

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Mrs. Lillian Momberger

(Address) 650 Bartlett Ave

15 Filed ..... 19 ..... Registrar

MAR 28 1929 C. HAMPSON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28 29.

17 I HEREBY CERTIFY, That I attended deceased from 3-15-29. 19 ..... to 3-25 19 29.

that I last saw h alive on 3-14 19 29

and that death occurred on the date stated above at 7.40 P. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Acute Anemia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) J. Wad Prentiss M. D.

(Address) 3-28-29 800 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Spring Hill Easton Md	March 30 19 29
20 UNDERTAKER Johnson & Son	ADDRESS 3611 Eastern

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Monaghan

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44517

E 44517

CERTIFICATE OF DEATH

REGISTERED NO. 12-50 57

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2608 W. Calvert ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret Agnes Monaghan

(a) RESIDENCE NO. 2608 W. Calvert ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 4 mos. 21 ds. How long in U. S., If foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Michael J. Monaghan

6 DATE OF BIRTH (month, day, and year) Nov. 6, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	58	4	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Patrick O'Brien

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Shannon

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Michael J. Monaghan
(Address) 2608 W. Calvert Street

15 Filed APR 28 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/27/29

17 I HEREBY CERTIFY, That I attended deceased from 3/4/29, 19..., to 3/27, 1929, that I last saw h[illegible] alive on 3/27, 1929 and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

diabetes mellitus

(duration) yrs. 18 mos. ds.

CONTRIBUTORY (Secondary) acute Coronary Thrombosis Thrombosis suddenly

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Examination

(Signed) J. F. Mcara M. D.

3/28 1929 (Address) 804 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 3/30 19 29

20 UNDERTAKER Henry W. Meares & Son

ADDRESS 2605 W Calvert

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION ... important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44518

CERTIFICATE OF DEATH

74-001 ✓ E 44518

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 1035 Fine. Ave. ST. 25-12 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Henry Dashiell Sr

(a) RESIDENCE NO. 1035 Fine Ave ST., WARD

(Usual place of abode. (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Grace F Dashiell

6 DATE OF BIRTH (month, day, and year) Dec 26-1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	3	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance-Office

(b) General nature of industry, business, or establishment in which employed (or employer) Boiler & Steel Plate Insurance Co

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER William H Dashiell

11 BIRTHPLACE OF FATHER (city or town) Maryland
(State or country)

12 MAIDEN NAME OF MOTHER Mary H Fleming

13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)

14 Informant Clarence Fenner

(Address) 1210 Eutaw St

15 Filed MAR 28 1929 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 27. 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb 27, 1929, to March 27, 1929, that I last saw h alive on March 26, 1929 and that death occurred, on the date stated above, at 11 12. m.

The CAUSE OF DEATH* was as follows:

(a) Uremia - Sclerosis Central Haemorrhage (2nd attack) 1st attack (duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Non haemorrhagic Nephritis (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symptoms

(Signed) Francis D. Murphy, M. D.

, 19 (Address) 704 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery

DATE OF BURIAL Mar 30th 1929

20 UNDERTAKER George Schilling & Sons

ADDRESS 1126 Eutaw St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 44519 HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001

E 44519

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 825 Hollins St., 16-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margarino Velleggia

(a) RESIDENCE NO. 825 Hollins ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3-27-29

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	0	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in whirh employed (or employer) None

(r) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Harry Velleggia

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Maria Selenzes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Harry Velleggia
(Address) 825 Hollins St

15 Filed ..... 19 ..... Registrar

APR 29 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/28/29

17 I HEREBY CERTIFY, That I attended deceased from 3/27/29, 19 to 3/28/29, 19, that I last saw h— alive on 3/28/29, 19 and that death occurred, on the date stated above, at 9:20 A m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contrarted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmrd diagnosis?

(Signed) Bernard J. Levy, M. D.

3/29, 19 29 (Address) 410 W Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	3/29 1929
20 UNDERTAKER	ADDRESS
Roberts Brooks & Son	Eutaw & Hollins sts

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 44520 HEALTH DEPARTMENT—CITY OF BALTIMORE E 44520

CERTIFICATE OF DEATH.

161-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 825 Hollins ST. (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Orlia Vrlleggia

(a) RESIDENCE NO. 825 Hollins ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5 If married, widowed, or divorced HUSBAND of (or) WIFE of -

6 DATE OF BIRTH (month, day, and year) 3-27-29

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	0	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Harry Velleggia

11 BIRTHPLACE OF FATHER (City or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Maria Selenzie

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Italy

14 Informant Harry Velleggia

(Address) 825 Hollins St

MAR 28 1929

C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/28/29 19

17 I HEREBY CERTIFY, That I attended deceased from 3/27, 19 29, to 3/28/29, 19,

that I last saw h[illegible] alive on 3/28/29, 19,

and that death occurred, on the date stated above, at 6 a C m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J. Sung, M. D.

3/29/29 (Address) 910 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL 3/29 1929

20 UNDERTAKER Robert Brooks & Son

ADDRESS Calhoun & Hollins Sts

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Bullman

E 44521 HEALTH DEPARTMENT—CITY OF BALTIMORE

X 60-901 E 44521

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST., 4-25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Samuel Bullmann

(a) RESIDENCE NO. 649 20 Franklin ST., Baltimore WARD (If non-resident give city or town and State) Md. Dallas Texas

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 24 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of Mrs. Bullman (or) ~~WIFE~~ of

6 DATE OF BIRTH (month, day, and year) Dec. 17, 1888

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
40	3 8	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stage Carpenter

(b) General nature of Industry, business, or establishment in which employed (or employer) Stage 015

(c) Name of employer —

9 BIRTHPLACE (city or town) Dallas, Texas (State or country)

PARENTS

10 NAME OF FATHER Mendel Bullman

11 BIRTHPLACE OF FATHER (city or town) Russia (State or country)

12 MAIDEN NAME OF MOTHER Jennie Patterman

13 BIRTHPLACE OF MOTHER (city or town) Russia (State or country)

14 Informant Mrs Ruby Bullman

(Address) 244 E. 31st Street

15 Filed MAR 25 1929, 19 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 27, 1929

17

I HEREBY CERTIFY, That I attended deceased from March 3, 1929, to March 27, 1929, that I last saw him alive on March 27, 1929 and that death occurred, on the date stated above, at 12:15 P. m.

The CAUSE OF DEATH* was as follows:

Thyroid disease (hyperthyroidism)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Detroit ?

Did an operation precede death? yes Date of March 27, 29

Was there an autopsy? no

What test confirmed diagnosis? B. M. - Thyroid gland.

(Signed) Christian Weinberg, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dallas. Texas

DATE OF BURIAL Mar. 29 1929.

20 UNDERTAKER Henry Sander & Sons Inc

ADDRESS Baltimore St & Broadway

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44522

CERTIFICATE OF DEATH

161-001

E 44522

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 814 E Pratt ST., 7-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph Crawford.

(a) RESIDENCE NO. 814 E Pratt ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 29/1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Col

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Harry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Minnie Winer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Father

(Address) 814 E Pratt St

15 Filed MAR 29 1929, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29 1929

17 I HEREBY CERTIFY, That I attended deceased from March 29, 19 29, to March 29, 19 29, that I last saw him alive on March 29, 19 29 and that death occurred, on the date stated above, at 9 — m.

The CAUSE OF DEATH* was as follows:

Prematur birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Emil F. Zeugler M. D.

3/29, 19 29 (Address) 1401 E. Pratt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loh Redeem	March 29 1929
20 UNDERTAKER	ADDRESS
M. W. E. Heppeldon	322 Aisquith

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44523

CERTIFICATE OF DEATH

161-001

E 44523

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1814 E Pratt ST. 2-4 WARD)

2—FULL NAME Mary Crawford

(a) RESIDENCE NO. 1814 E Pratt ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 29 1929

7 AGE	Years	Months	Days	If LESS than 1 day, 2 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Harry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Minnie Winer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Harry Crawford.
(Address) 1814 E Pratt St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29 1929

17 I HEREBY CERTIFY, That I attended deceased from March 29, 1929, to March 29, 1929, that I last saw h[illegible] alive on March 29, 1929 and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Prematura birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Lael Ziegler, M. D.

3/29, 1929 (Address) 1002 E. Pratt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	March 31 1929
20 UNDERTAKER	ADDRESS
M. W. E. Dippel & Co.	32 S. Arm

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAR 29 1929

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44524

CERTIFICATE OF DEATH

75-002

E 44524

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2000 Wilkens Ave ST., 70-28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rudolph Zimmermann

(a) RESIDENCE NO. 2000 Wilkens Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if foreign birth? 47 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Zimmermann

6 DATE OF BIRTH (month, day, and year) June 26 1856

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72.	9	2.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocery Store

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Johannah Liber

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary Zimmermann

(Address) 2000 Wilkens Ave

15 Filed MAR 28 1929 C. HAMDON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28, 29.

17

I HEREBY CERTIFY, That I attended deceased from March 6th, 1929, to March 27, 1929, that I last saw h[illegible] alive on March 27, 1929, and that death occurred, on the date stated above, at 7.45 A. m.

The CAUSE OF DEATH* was as follows:

Paraplegia from Hemorrhage into Cord

(duration) yrs. mos. 24 ds.

CONTRIBUTORY (Secondary) Gangrene of Bladder Hemorrhage from

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination Spinal

(Signed) Joseph Jachues, M. D.

March 28 1929 (Address) 320 Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	March 30 1929

20 UNDERTAKER John H. Feipel & Bro. ADDRESS 821 W. Lafayette

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Margaret A. Cook ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 44525

CERTIFICATE OF DEATH

E 44525

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1524 N. Caroline ST., 9-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret A. Cook

(a) RESIDENCE NO. 1524 N. Caroline ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. 3 mos. 11 ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas J. Cook

6 DATE OF BIRTH (month, day, and year) Dec. 16, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	75	3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John Richards

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Scotland

12 MAIDEN NAME OF MOTHER ---------

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Howard T. Cook
(Address) 1524 N. Caroline St.

15 Filed MAR 29 1929 C. HAMPSON JONES, M. D. Registrar

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 27/29

17 I HEREBY CERTIFY, That I attended deceased from March 17, 1929, to March 27, 1929, that I last saw him alive on March 27, 1929 and that death occurred, on the date stated above, at 4.45 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Exhaustion

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) ... yrs. ... mos. 11 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John L. Henderson, M. D.

, 19 (Address) 1420 N. Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	3/30 19 29

20 UNDERTAKER Henry U. Deal & Son ADDRESS 805 N. Calvert

Spec.—1-12-23—M&T—500 Blks.

E 44526

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

E 44526

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1720 Carey ST. 15-21 (WARD)

2-FULL NAME Lorraine D Smallwood

(a) RESIDENCE NO. 1720 Carey ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) aug 28, 1928

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
		6	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto md.

PARENTS

10 NAME OF FATHER John. W. Smallwood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. md.

12 MAIDEN NAME OF MOTHER Bernice Purvey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto md.

14 Informant John. W. Smallwood.

(Address) 1720 n. Carey St

15 Filed MAR 29 1929 C. HAMPSON JONES, M. D. Registrar

By —

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/27 1929

17 I HEREBY CERTIFY, That I attended deceased from 3/20, 1929, to 3/27 29,

that I last saw h alive on 3/27, 19 29

and that death occurred, on the date stated above, at 2 m

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Emil Klutz, M. D.

3/29, 19 29 (Address) 2134 Dr

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn cemetery

DATE OF BURIAL mar 29, 1929

20 UNDERTAKER Thomas. E. Kelson

ADDRESS 1001 W Fayette St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44527

CERTIFICATE OF DEATH

89 ✓

E 44527

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 513 S Kenwood ave ST., 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Isabelle Ey.

(a) RESIDENCE NO. 513 S Kenwood ave ST.

(Usual place of abode) WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced. (write the word) Widow

a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Ey

6 DATE OF BIRTH (month, day, and year) July 7-1862

7 AGE Years 66 Months 4 Days 21 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt

PARENTS

10 NAME OF FATHER Antone Amon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dorothea

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Ey.

(Address) 513 S. Kenwood ave

15 Filed APR 29 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 28, 29

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1927, to Mar 28, 1929.

that I last saw h alive on Mar 27, 1929

and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Angina pectoris

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Heart Lesion

(Signed) O Thomas, M. D.

3/28, 1929 (Address) 3013 Ellwood ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oaklawn

DATE OF BURIAL Mar. 30, 1929

20 UNDERTAKER John A. Moran

ADDRESS 3000 E. Balto

IMPORTANT.—Use typewriter or pen and ink. Write in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

Dora Werner ✓

E 44528 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

E 44528

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 24 S. Highland Ave. ST 26-27 WARD)

2-FULL NAME Dora Werner

(a) RESIDENCE NO. 24 S. Highland Ave. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Henry A. Werner

6 DATE OF BIRTH (month, day, and year) Nov. 26- 1848

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min
80	4	;;;	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Zimmerman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mr. Andrew J. Brennan

(Address) 24 S. Highland Ave.

15 Filed MAR 29 1929 SAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28- 1929

17 I HEREBY CERTIFY, That I attended deceased from Mar 3, 1929, to Mar 28, 1929, that I last saw h alive on Mar 28, 1929 and that death occurred, on the date stated above, at 1:30 A m

The CAUSE OF DEATH* was as follows:

Acute Dilatation of the Heart-
Infirmities of Old age

(duration) yrs. mos 20 days

CONTRIBUTORY (Secondary) Acute Indigestion
and Colitis but not contributing (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? (Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wright L. Swisher, M. D.

3/29, 1929 Address 1337 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetary

DATE OF BURIAL 3/30/1929

20 UNDERTAKER Chas. F. Evans & Son

ADDRESS 1118 W. Mt. Royal Ave.

MAJOR should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

Ellen Nestor

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44529

CERTIFICATE OF DEATH.

90 E 44529

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 916 E. Chase Street ST. 10-14 WARD)

2-FULL NAME Ellen Nestor

(a) RESIDENCE NO. 916 E. Chase St. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of Patrick Nestor

6 DATE OF BIRTH (month, day, and year) Nov. 4- 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	4	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Michael Flatley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Fitzmaurice

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Julia Flanagan

(Address) 916 E. Chase Street

15 Filed MAR 29 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Feb 24 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 12 1928 to March 27 1929, that I last saw her alive on March 27 1929 and that death occurred, on the date stated above, at 1.30 A. m

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) ? yrs. ? mos ds

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 0

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical symptoms

(Signed) L. McCarthur, M. D.

3/28, 1929 (Address) 1114 Hollins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	3/30 1929

20 UNDERTAKER Chas. S. Krause & Son ADDRESS 118 W. North Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44530

CERTIFICATE OF DEATH

129 E 44530

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 217 S. Mount St. St., 19-28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary E. Jones

(a) RESIDENCE NO. 217 S. Mount St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

a If married, widowed, or divorced HUSBAND of (or) WIFE of Late George H. Jones

6 DATE OF BIRTH (month, day, and year) Aug. 18, 1857.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
71	7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary Young

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mr. Martin R. Jones

(Address) 1712 Wilkens Ave.

15 Filed 3-29-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 27, 29

17

I HEREBY CERTIFY, That I attended deceased from Mar 1, 1929, to Mar. 27, 1929, that I last saw h alive on Mar. 27, 1929, and that death occurred, on the date stated above, at 1:30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Int. Nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Urine Analysis Etc.

3/29/29 (Signed) Chas. Norton, M. D.

(Address) 888 W Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL March 30 19 29

20 UNDERTAKER Harry N. Witzke

ADDRESS 5314 Harford

important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44531

CERTIFICATE OF DEATH.

E 44531

94-001

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1139 Washington Boul 94-29 St., Ward)

2-FULL NAME Emma L. Cain

(a) RESIDENCE NO. 1139 Washington Boulevard Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 ~~Single~~, Married, ~~Widowed~~, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: J. W. Cain

6 DATE OF BIRTH (month, day, and year): Nov 30 1861

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	67	3	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Nume of employer

9 BIRTHPLACE (city or town):

(State or country) Baltimore

PARENTS

10 NAME OF FATHER James Cain

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Baltimore

12 MAIDEN NAME OF MOTHER ? Kelley

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Unknown

14 Informant: John W. Cain Jr

(Address) 1139 Washington Blvd

MAR 29 1929

C. HAMPSON JONES, M. D.

15 Filed ..... 19.....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/27 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Arthritis - Arterio-Sclerosis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. H. Brook M. D.

(Coroner) Sub Dist

3/29 1929 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Date of Burial Mar. 29 1929

UNDERTAKER: Wm. J. Tuckner Sons ADDRESS N. Y & Pa

very important. See instructions on back of certificate. Exact statement of OCCUPATI

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44532

CERTIFICATE OF DEATH

74-001

E 44532

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3111 Milford Ave ST., 26-67 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Francis Shea

(a) RESIDENCE NO. 3111 Milford Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 0 mos. 4 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louisa W. Shea

6 DATE OF BIRTH (month, day, and year) Mar. 23, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	0	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Claim Investigator

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B & O R.R.

9 BIRTHPLACE (city or town) (State or country) Talbot Co Md

PARENTS

10 NAME OF FATHER John Shea

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary A. Drew

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Mr. Wm. P. Carr

(Address) 3111 Milford Ave

15 Filed ..... 19 ..... HAMILTON JONES, M. D. Registrar

MAR 29 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 27, 1929

17 I HEREBY CERTIFY, That I attended deceased from Mar 15, 1929, to Mar 27, 1929.

that I last saw h.i.m alive on Mar 27, 1929

and that death occurred, on the date stated above, at 12.10 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Karl J. Steinmeller, M. D.

3/27, 1929 (Address) 725 Medical Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem.

DATE OF BURIAL Mar 30, 29

20 UNDERTAKER Wm. J. Rickner & Sons

ADDRESS North & Pa

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44533

CERTIFICATE OF DEATH

106-001

E 44533

REGISTERED NO.

1-PLACE OF DEATH The Church Home & Infirmary

City of BALTIMORE: (No. 6-9 St. Ward)

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Albert McBride

(a) RESIDENCE NO. Frederick Md. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 Color or Race White

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day ....hrs. or ....min.
	about 57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown

(State or country)

14 Informant Caroline McMichael

(Address) 7 Trail Ave.

15 Filed ..... 19.. Registrar

R 29 1929 Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb. 17, 1929, to March 29, 1929, that I last saw him alive on March 29, 1929, and that death occurred, on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Aplastic Anaemia

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of March 5, 1929

Was there an autopsy? Yes

What test confirmed diagnosis? Blood counts. Autopsy

(Signed) Fred M. Landon, M. D.

19 (Address) The Church Home & Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, State (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 BURIAL, CREMATION or REMOVAL Date of Burial Mar 31 1929

20 UNDERTAKER C E Cline

ADDRESS Frederick Md

very important. See instructions on back of certificates. EXACT Statement of OCCUPATION is

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44534

CERTIFICATE OF DEATH.

65 E 44534

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital (ST.) 17-24 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bessie Hughes Temple.

(a) RESIDENCE NO. 519 W. Lanvale St. ST., ... WARD .

(Usual place of abode)

Length of residence in city or town where death occurred 1yr yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: C.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Temple

6 DATE OF BIRTH (month, day, and year): Jan 15 1900

7 AGE: Years 29 | Months 2 | Days 11 | If LESS than 1 day, hrs. or min. 6

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Marshall Hughes

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Winters

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Winters.

14 Informant (Address): Harvey Temple 519 W. Lanvale St.

15 Filed MAR 29 1929 HARRY M. JONES, M. D., Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 26 1929

17

I HEREBY CERTIFY, That I attended deceased from March 24. 1929. to March 26. 1929.

that I last saw her alive on March 26. 1929.

and that death occurred, on the date stated above, at 8 20 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema.

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Myelogenous Leukemia.

(duration) yrs. 3-5 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Autopsy.

(Signed) Louis H. Longstaff, M. D.

3/26 1929 (Address) Emil Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: Mar 29 1929

UNDERTAKER: Mrs. R. G. Elliott — ADDRESS: 1726 Eastlan

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44535

CERTIFICATE OF DEATH

25-001

E 44535

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Sydenham Hospital 26-31 WARD).

2—FULL NAME Theodore Kaitis

(a) RESIDENCE NO. 640 Macon 13th St — ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male White | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 22, 1927

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	3	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Leon Kaitis

11 BIRTHPLACE OF FATHER (city or town) Greece
(State or country)

12 MAIDEN NAME OF MOTHER Mary Kiamos

13 BIRTHPLACE OF MOTHER (city or town) Greece
(State or country)

14 Informant Leon Kaitis
(Address) 640 — 13th St.

15 Filed ..... 19 .....

E. LIVINGSTON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28 1929

17

I HEREBY CERTIFY, That I attended deceased from March 26, 1929, to March 28 1929

that I last saw h.. alive on March 28, 1929

and that death occurred, on the date stated above, at 10:25 m.

The CAUSE OF DEATH* was as follows:

Chicken Pox

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? 640 — 13th St —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings & X-ray

(Signed) Addison Crabtree M. D.

3-28 1929 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem.	Mar 29 1929
20 UNDERTAKER Charles H. Kelmer	ADDRESS 1532 Harlem

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

E 44536
PLACE OF DEATH

County Baltimore

Village or City Baltimore (No. 500 N. Glover St.: 7-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Susan M. Tyler

E 44536
STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word): Widowed

6 DATE OF BIRTH: May (Month) 17 (Day) 1852 (Year)

7 AGE: 76 yrs. — mos. 21 ds. If LESS than 1 day hrs. or 16 min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work: Laundress
(b) General nature of industry business, or establishment in which employed or (employer)

9 BIRTHPLACE (State or country): Maryland

PARENTS

10 NAME OF FATHER: Saml Sharpley
11 BIRTHPLACE OF FATHER (State or country): Maryland
12 MAIDEN NAME OF MOTHER: Susan M Sharpley
13 BIRTHPLACE OF MOTHER (State or Country): Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ely Capt

(Address) 500 N. Glover St Baltimore Md

15 Filed MAR 29 1929 192 STATE REGISTRAR, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: 3 (Month) 28 (Day) 29 (Year) 1929

17 I HEREBY CERTIFY, That I attended the deceased from 3-27-29 to 3-28-29 that I last saw h alive on 3-27-29 and that death occurred on the date stated above, at 8.15 PM

The CAUSE OF DEATH * was as follows:

Mitral Regurgitation

(Duration) yrs. mos. ds.

Contributory or Secondary Acute Cardiac Dilatation

(Duration) yrs. mos. ds.

(Signed) [illegible] M. D.

192 (Address) 500 N. Glover St

* State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Harpers Island Md — DATE OF BURIAL: May 31st 1929

20 UNDERTAKER: L.E. LeCompte Son — ADDRESS: Cambridge Md.

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting U. S. No. 1.

Statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44537

CERTIFICATE OF DEATH.

90 E 44537

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3316 N. Calvert ST. 12-4-4 WARD)

2-FULL NAME Edgar Boyer Britton

(a) RESIDENCE NO. 3316 N. Calvert ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, ~~Widowed, or Divorced~~ HUSBAND of (or) WIFE of Eliza T. Britton

6 DATE OF BIRTH (month, day, and year) Sept 22 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician

(b) General nature of industry, business, or establishment in which employed (or employer) 054

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Millington Md.

PARENTS

10 NAME OF FATHER Thomas Britton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Louis M Coseley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Mabel Lovegrove

(Address) 3316 Calvert St.

15 Filed MAR 29 1929 HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 27 1929

17 I HEREBY CERTIFY, That I attended deceased from Mar 21, 19 29, to Mar 27, 19 29, that I last saw h alive on Mar 26, 19 29, and that death occurred, on the date stated above, at 6:00 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac decompensation

(hypertension)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Erysipelas

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. Lowe Jones, M. D.

Mar 28, 19 29 (Address) 1 W Chesapeake

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Millington Md.	Mar 30 19 29
20 UNDERTAKER Hughes & Jones Inc	ADDRESS 1 W Read

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44538

E 44538

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

Registered No. .....

City of BALTIMORE: (No. 703 Woodbourne Ave St., 27-46 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernestine Day Hanway

(a) Residence No. 703 Woodbourne Ave St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Milford Hanway

6-DATE OF BIRTH (month, day and year) Feb 2 1867

7-AGE. 62 yrs. 1 mos. 26 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. at home

(b) General nature of industry, business, or establishment in which employed (or employer). 37

(c) Name of employer. .....

9-BIRTHPLACE (city or town). Jonesboro N. C.
(State or Country).

PARENTS.

10-NAME OF FATHER. George Washington Day

11-BIRTHPLACE OF FATHER (city or town). N.Y.
(State or Country).

12-MAIDEN NAME OF MOTHER. Olive Field

13-BIRTHPLACE OF MOTHER (city or town). Portland
(State or Country). Maine

14-

(Informant) Mr. Chas. Hanway

(Address) 703 Woodbourne Ave

MAR 29 1929

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 29

17- I HEREBY CERTIFY, That I attended deceased from March 22 19 29 to March 28 19 29

that I last saw h.r alive on March 28 19 29

and that death occurred, on the date stated above at 2:45 P. m.

The CAUSE OF DEATH* was as follows:

Chr Myocarditis,
Acute nephritis
Mitral & aortic Insufficiency

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) E. C. Brack M. D

March 29, 1929 (Address) 58 E Chase St

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New York N.Y. DATE OF BURIAL. March 31 19 29

20-UNDERTAKER. Hopkins Place ADDRESS 1st & Park

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 44539

Forsythe 424 E North Ave

73 E 44539

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 405 East 20th St. 1219 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James W. Strickland

(a) RESIDENCE NO. 405 East 20th ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Mary K. Strickland

6 DATE OF BIRTH (month, day, and year) June 22, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	64	9	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Turpentine

(b) General nature of industry, business, or establishment in which employed (or employer) Operator 086

(c) Name of employer

9 BIRTHPLACE (city or town) Durham

(State or country) North Carolina

PARENTS

10 NAME OF FATHER James W. Strickland

11 BIRTHPLACE OF FATHER (city or town) Durham

(State or country) North Carolina

12 MAIDEN NAME OF MOTHER Nancy Marian

13 BIRTHPLACE OF MOTHER (city or town) Durham

(State or country) North Carolina

14 Informant Mary K. Strickland

(Address) 405 East 20th St

15 Filed MAR 30 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28-29

17 I HEREBY CERTIFY, That I attended deceased from March 20, 1929, to March 28, 1929, that I last saw him alive on March 29, 1929 and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Ascending paralysis

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No.

(Signed) Hugh Forsythe, M. D.

March 29, 1929 (Address) 424 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sartwood Cemetery — DATE OF BURIAL 3/31/29

20 UNDERTAKER William Cook — ADDRESS 1217 St Paul St

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 44540

HEALTH DEPARTMENT—CITY OF BALTIMORE

2220 Harrison Ave

CERTIFICATE OF DEATH

E 44540

1—PLACE OF DEATH

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 5505 Yupon (Pk) Ave WARD)

2—FULL NAME Mary E Keefer

(a) RESIDENCE NO. 5505 Yupon Oak WARD
(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6a If married, widowed or divorced (or) WIFE of: Henry C Keefer

6 DATE OF BIRTH (month, day, and year): Oct 28 184

7 AGE — Years: 81 — Months: 5 — Days: — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sr Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Silas Sisk

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Catherine S Ruff

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Wm F Derr

(Address) 5505 Yupon Oak

15 Filed ..... 19 ..... Registrar

MAR 30 1929 C. HARRY JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 28 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1928, to March 28, 1929

that I last saw h-e alive on March 26, 1929

and that death occurred, on the date stated above, at 1 9 m.

The CAUSE OF DEATH* was as follows:

arterio-sclerosis - ~~myocarditis~~

cerebral Hemorrhage + paralysis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) myocarditis about 6 mos. ds.

(duration) yrs.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Walter S Tibbett, M. D.

March 28 19 29 (Address) 2220 Harrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Westminster Cemetery — DATE OF BURIAL: 3/30 1929

20 UNDERTAKER: William Cook — ADDRESS: 1217 St Paul

important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 44541 HEALTH DEPARTMENT—CITY OF BALTIMORE E 44541

CERTIFICATE OF DEATH.

139

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hosp. St 6-9 WARD)

2-FULL NAME Catherine Smith

(a) RESIDENCE NO. 1932 E. Fayette St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. J. Smith

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	52	9	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Home

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER [illegible] Johnny

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER [illegible] Snow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Wm. J. Smith (Address) 1932 E. Fayette St

15 Filed MAR 30 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-30 1929

17

I HEREBY CERTIFY, That I attended deceased from 3-8, 1929, to 3-30, 1929,

that I last saw her alive on 3-30, 1929,

and that death occurred, on the date stated above, at 12.05 A m.

The CAUSE OF DEATH* was as follows:

Paralytic Ileus
Toxemia
Myocardial failure

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Myomata uteri; intraligamentary cysts. (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of 3-19-29

Was there an autopsy? No

What test confirmed diagnosis? Operation & Clinical Course

(Signed) Benjamin Katz, M. D.

(Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL 4-2-29

20 UNDERTAKER [illegible]

ADDRESS [illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44542

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

129 E 44542

REGISTERED NO.

City of BALTIMORE: (No. 116 N. Maderia St. St. 6-18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emma E. Evans

(a) RESIDENCE NO. 116 N. Maderia St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of David Evans

6 DATE OF BIRTH (month, day, and year) March 12/1868

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	61	0	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Rag Sorter Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Frank & Co.

9 BIRTHPLACE (city or town)

(State or country) Pa.

PARENTS

10 NAME OF FATHER John L. Yeager

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Pa.

12 MAIDEN NAME OF MOTHER Harriet Smith

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Pa.

14 Informant Miss Minnie W. Yeager

(Address) ~~43 Bethel ST. Columbia Pa.~~

15 Filed C. 19

C. HARRISON JONES, M. D. Registrar

R 30 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 27/29

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Cardiac-Nephritic Disease

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) J. H. Wolff (Coroner) M. D.

3/29/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the state.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: MT. Carmel Cem. Date of Burial: 3/30/29

20 UNDERTAKER Philip Herwig ADDRESS 2016 Eutaw St.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bka.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44543

CERTIFICATE OF DEATH

31

E 44543

REGISTERED NO. 3697

1-PLACE OF DEATH

City of BALTIMORE: (No. 1557 Argyle Ave. St.) (14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Adams

(a) RESIDENCE NO. 1557 Argyle Ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 30, 1908

7 AGE: Years 21 Months Days

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Work

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town): Charles Co.

(State or country): Md

PARENTS

10 NAME OF FATHER: Charles Adams

11 BIRTHPLACE OF FATHER (City or town): Charles Co

(State or country): Md

12 MAIDEN NAME OF MOTHER: Rose White

13 BIRTHPLACE OF MOTHER (city or town): Charles Co

(State or country): Md

14 Informant: Mrs Ida Beal

(Address)

15 Filed ..... 19 ..... C. HARRISON JONES, M. D. Registrar

MAR 30 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

March 28, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 26, 1929, to March 28, 1929, that I last saw h[er] alive on March 27, 1929, and that death occurred, on the date stated above, at 2:30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Pneumonic Tuberculosis

(duration) ..... yrs. ..... mos. 42 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopical

(Signed) W. Caldwell Jones, M. D.

, 19 (Address) 1123 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dr Bekes Den — Date of Burial 3-30 1929

20 UNDERTAKER: Daniel Earley — ADDRESS 916 Ea Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44544

CERTIFICATE OF DEATH

90 ✓ E 44544

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE. (No. Preston Apts ST. 12-14 WARD).

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Isabel Power Neale

(a) RESIDENCE NO. Preston Apts ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 11 mos. 5 ds. How long in U. S., If foreign birth? 70 yrs. 11 mos. 5 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anthony M. Neale

6 DATE OF BIRTH (month, day, and year): April 24 1858

7 AGE — Years: 70 | Months: 11 | Days: 5 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Baltimore. Maryland.

PARENTS

10 NAME OF FATHER: William D. Power

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown. unknown.

12 MAIDEN NAME OF MOTHER: Julia A. Zollinger

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Harrisburg Penna

14 Informant: Miss Isabel P. Neale (daughter)

(Address): Preston Apts. City.

15 Filed ..... 19.. C. HAMPSON JONES, M. D. Registrar.

R 30 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 29 - 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 27, to March 28, 1929, that I last saw her alive on 3/28/29 3/29/29, 19.., and that death occurred, on the date stated above, at 1:30 A.M.

The CAUSE OF DEATH* was as follows:

Myocarditis

Mitral Insufficiency

(duration) 2 yrs. 8 mos. ds.

CONTRIBUTORY (Secondary): Pulmonary Edema

(duration) 3 yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) W. M. Brody M. D.

19.. (Address) 1403 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Green Mount Cemetery — DATE OF BURIAL: Mar 30 1929.

20 UNDERTAKER: Stewart & Co. — ADDRESS: Balto

important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Stachlin)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44545

CERTIFICATE OF DEATH.

118 E 44545

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1411 Eight ST. 24-23 WARD)

2-FULL NAME Rosina Barbara Stachlin

(a) RESIDENCE. NO. 1411 Eight ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emil Stachlin

6 DATE OF BIRTH (month, day, and year): Jan 30 1874

7 AGE — Years: 55 — Months: 1 — Days: 29 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Christoph Dederer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Catherine Kohler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Geo Dederer (Brother)
(Address) 1009 Hanover St

15 [illegible] . 19 . C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3-29 1929

17 I HEREBY CERTIFY, That I attended deceased from March 27 . 19 29. to March 29 . 19 29.
that I last saw h alive on March 28 . 19 29.
and that death occurred, on the date stated above, at 7A m.
The CAUSE OF DEATH was as follows:

Intestinal obstruction

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Acute dilatation of heart

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of None

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Chas A Fetterhoff M. D.

. 19 (Address) 1807 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Emmanuel Laurelle	4-1 1929

20 UNDERTAKER: Mrs Chas A G Robde — ADDRESS: 2327 Edmondson Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

AR 30 1929

Spec.—1-12-23—M&T—500 Bks.

E 44546

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44546

CERTIFICATE OF DEATH.

REGISTERED NO. 905

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1920 E 29th ST., 9-46 WARD)

2-FULL NAME Frederick C. Meyer.

(a) RESIDENCE No. 1920 E. 29th ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sophia Meyer

6 DATE OF BIRTH (month, day, and year) June 26 1850

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
73	9	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Herman Meyer.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Christina Beck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Sophia Meyer (Address) 1920 E. 29th St.

Filed MAR 30 1929, 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29 1929

17 I HEREBY CERTIFY, That I attended deceased from March 23, 1929, to March 29, 1929, that I last saw h— alive on March 29, 1929 and that death occurred, on the date stated above, at 3.35 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) A G Jones M. D.

(Address) 720 N. Wolfe Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park. | DATE OF BURIAL April 1. 1929

20 UNDERTAKER Chas. Mc. John T. Pengel & Son ADDRESS 501 N. Fayette St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCU-TION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rks.

E 44547 E 44547

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH U.S. Marine Hospital, Baltimore, Md.

CITY OF BALTIMORE: (No. ST., WARD) 1974 90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm. Stanford Nichols

(a) RESIDENCE No. 591 Orchard St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 4, 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	8	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman

(b) General nature of industry, business, or establishment in which employed (or employer) Seaman

(c) Name of employer SS "Northumberland"

9 BIRTHPLACE (city or town) (State or country) Cambridge, Md.

PARENTS

10 NAME OF FATHER Luke Nichols

11 BIRTHPLACE OF FATHER (city or town) (State or country) Town Point, Md.

12 MAIDEN NAME OF MOTHER Mary Jane Cook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Records, U.S. Marine Hospital (Address)

15 Filed MAR 30 1929 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 27 19 29

17

I HEREBY CERTIFY, That I attended deceased from December 1, 19 29, to March 27, 19 29, that I last saw him alive on March 27, 19 29, and that death occurred, on the date stated above, at 11:40 P. m.

The CAUSE OF DEATH* was as follows:

Valvular disease of heart, mitral insufficiency

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical & laboratory findings

(Signed) Ralph E. Porter, M. D.

3/28 19 29 (Address) U.S. Marine Hospital, Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cambridge Md DATE OF BURIAL 3/30 19 29

20 UNDERTAKER Samuel T. Wensley ADDRESS 578 N. Caroline

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 44548

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-09

E 44548

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 308 E. Fort Ave. ST 24-33 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles A. Young

(a) RESIDENCE NO. 308 E. Fort Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. 0 mos. 26 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 1 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	0	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lab

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Capt. Philip J. H. Young

11 BIRTHPLACE OF FATHER (city or town) Salem N. J.
(State or country)

12 MAIDEN NAME OF MOTHER Sarah A. Rutter

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Mr. Young (brother)
(Address) 308 E. Fort Ave

15 Filed MAR 30 1929, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-27-1929

17 I HEREBY CERTIFY, That I attended deceased from 3.15, 1929 to 3.27, 1929

that I last saw him alive on 3.27, 1929

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) yrs. mos 17 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos 4 ds.

18 Where was disease contracted ~, If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) Edward Norris, M. D.

3.28, 1929 (Address) 107 East west st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Pk Cem

DATE OF BURIAL 3/30 1929

20 UNDERTAKER J. Few McCully

ADDRESS 130 E. Fort Ave

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 44549

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

E 44549

1—PLACE OF DEATH Earl Court Apts.

REGISTERED NO.

CITY OF BALTIMORE: (No. St. Paul & Preston ST.S, 11-19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James R. Tucker

(a) RESIDENCE NO. Earl Court Apts. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 9, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	9	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real estate broker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Geo. W. Tucker

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Rebecca Williams

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14

Informant Bertha W. Tucker

(Address) 1527 Park Ave.

15

Filed ....., 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 27/1929.

17

I HEREBY CERTIFY, That I attended deceased from July 29, 19 28, to March 27, 19 29,

that I last saw him alive on March 29, 19 29

and that death occurred, on the date stated above, at 5 30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Hypertension

Mitral Insufficiency

(duration) 11 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) W. D. Mackay, M. D.

19 (Address) 140 S Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Mar. 30, 1929

20 UNDERTAKER M P Mitchell

ADDRESS John O. Mitchell & Sons, 1900 Eutaw Pl.

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Jurska

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44550 | CERTIFICATE OF DEATH | E 44550

100-81

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 807 S. Bond Street ST. 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Dorthy Jurska

(a) RESIDENCE NO. 807 S. Bond Street ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if foreign birth? 27 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of Stanislaw Jurski

6 DATE OF BIRTH (month, day, and year) April 10-1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Poland
(State or country)

PARENTS

10 NAME OF FATHER Antoni Jakzewski

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER Alexsandra Pagenska

13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)

14 Informant Stanislaw Jurski

(Address) 807 S. Bond Street

Filed Mar 30, 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29

17 I HEREBY CERTIFY, That I attended deceased from Mar 27, 19 29, to Mar 29, 19 29, that I last saw her alive on Mar 28, 19 29 and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows: Broncho Pneumonia

(duration) 6 da.

CONTRIBUTORY (Secondary) Cy Laudism

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What was confirmed diagnosis? —

(Signed) C. Hampson Jones, M. D.

, 19 (Address) 1436 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cemetery	April 2, 19 29
20 UNDERTAKER George A. Weber	ADDRESS 708 S. Amity

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 44551 3661

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 101-001 E 44551

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 7-4 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Chester Fritz

(a) RESIDENCE NO. 30 Townsend st Laurel Delaware ST., ... WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 7 ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Nov 1928

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		4 mo.		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Laurel Del.

PARENTS

10 NAME OF FATHER Chester

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Anna Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... Registrar

R 30 1929 C. HARRISON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29-1929

17 I HEREBY CERTIFY, That I attended deceased from March 22, 1929, to March 29, 1929, that I last saw him alive on March 29, 1929, and that death occurred, on the date stated above, at 11:30 P m.

The CAUSE OF DEATH* was as follows:

Congenital Malformation of the Bile Ducts.

(Acute)

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pneumonia

..... (duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of 3/26/29

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) [illegible], M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Del — DATE OF BURIAL 3/30/29

20 UNDERTAKER Joseph Ahrens — ADDRESS 221 Bway

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44552

CERTIFICATE OF DEATH

E 44552

1—PLACE OF DEATH

REGISTERED NO. 2179

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST. [illegible] WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harry C. Reynolds

(a) RESIDENCE NO. 1008 S Paca ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred [illegible] yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed, or Divorced~~, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Katie V. Reynolds

6 DATE OF BIRTH (month, day, and year): April 25-1864

7 AGE: Years 64 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Engineer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Stephen Reynolds

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Emma Edwards

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Katie V. Reynolds

(Address): 1008 S. Paca St.

15 Filed [illegible], 19 [illegible]

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/28/29

17 I HEREBY CERTIFY, That I attended deceased from 3/18, 19 29, to 3/28, 19 29

that I last saw him alive on 3/28, 19 29

and that death occurred, on the date stated above, at 12:57 m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 3/19/29

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. C. Zimmerman, M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: April 1 1929

20 UNDERTAKER: J. A. Rowe & Son.

ADDRESS: 703 Monument

Important. See instructions on back of certificates.

30 1929

Cor.—1-12-23—M&T—100 Bks.

E 44553 HEALTH DEPARTMENT—CITY OF BALTIMORE E 44553

CERTIFICATE OF DEATH.

REGISTERED NO. 188

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Homan Memorial Hospital ST., 49 WARD)

2-FULL NAME Curtis Sherman

(a) RESIDENCE NO. 3300 Brentwood ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	C.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 1907

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
22	23			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Sherman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Louise Parker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Louise Sherman
(Address) 3300 Brentwood ave

15 Filed MAR 30 1929, 192 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/27 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fractures of Skull & Internal Injuries - Motor Cycle Accident and shock

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) [signature], M. D. (Coroner.)

3/29, 1929 (Address) 1632 Roland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pleasant Rest Cem	Mar 30 1929
UNDERTAKER Wm. R. G. Elliott	ADDRESS 1725 Carlton ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 44554

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 44554

CERTIFICATE OF DEATH

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS [redacted] REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. [redacted] ST. 16-2 WARD)

2—FULL NAME William Thomas Turner Freestman.

(a) RESIDENCE NO. 1515 ~~Lawrence~~ ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Carolton Turner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Anna ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Records of
(Address) BALTIMORE CITY HOSPITALS [redacted]

15 Filed [redacted], 19 Registrar

MAR 30 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 26, 19 29 to March 29, 19 29

that I last saw him alive on March 29, 19 29

and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia
acute myocarditis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Auricular fibrillation
Chr. myocarditis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? P.M. Physical Exam

(Signed) [redacted] M. D.

, 19 (Address) BALTIMORE CITY HOSPITALS [redacted]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	April 1 19 29
20 UNDERTAKER Thomas E. Kelem	ADDRESS 1303 Pennsylvania Ave

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44555

E 44555

CERTIFICATE OF DEATH

REGISTERED NO. 1956

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3620 Pensylvania Ave ST., 19th WARD)

2—FULL NAME Deborah Saltz

(a) RESIDENCE NO. 3620 Pensylvania Ave ST., 19th WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Jacob Saltz

6 DATE OF BIRTH (month, day, and year) 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis
(Address) 1439 E. Baltimore St

15 Filed MAR 30 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29, 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan. 27, 1929, to March 29, 1929, that I last saw h alive on March 29, 1929, and that death occurred, on the date stated above, at 11.30 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the upper jaw (left)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) ✓

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Path

(Signed) Sidney I. Levy, M. D.

March 19 29 (Address) 2324 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Sinai Cemetery	3/31/29
20 UNDERTAKER	ADDRESS
Jack Lewis	1439 E Balto St

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 44556

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 44556

90

REGISTERED NO.

1—PLACE OF DEATH

BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE: (No. 1-1 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Flynn

(a) RESIDENCE NO. 1113 S Bond ST., 26 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	~~Married~~ Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late James S. Flynn.

6 DATE OF BIRTH (month, day, and year) [illegible] 1835

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
69	~~Yrs~~	7	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John Boyle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Lawler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant

(Address)

15 Filed MAR 30 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/28/29

17 I HEREBY CERTIFY, That I attended deceased from 3/14, 19 25, to 3/28, 19 29, that I last saw h alive on 3/28, 19 29, and that death occurred, on the date stated above, at 12.30 A m.

The CAUSE OF DEATH* was as follows:

Primary Cause Chronic Myocarditis

Contributory Myocardial Insufficiency

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 3/27/29

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) H. Del Walsh, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	March 30 1929
20 UNDERTAKER	ADDRESS
Lilly & Sons	4038 Norfolk Ave

Important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 44557

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 44557

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 707 E. Biddle St ST. 10-15 WARD)

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas P. Kirby

(a) RESIDENCE NO. 1112 Forest St ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary E. Kearney

6 DATE OF BIRTH (month, day, and year): June 27, 1855

7 AGE: Years 70 | Months 8 | Days 28 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Serg. of Police

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Balto Police Dept.

9 BIRTHPLACE (city or town) (State or country): Baltimore Co Md.

PARENTS

10 NAME OF FATHER: Dennis Kirby

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Ellen Murphy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Mrs Mary E. Kirby 707 E. Biddle St

15 Filed , 19 C. HAMPSON JONES, M. D. Registrar

MAR 30 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar. 28, 1929

17

I HEREBY CERTIFY, That I attended deceased from Feb 15, 19 28, to Mar 28, 19 29,

that I last saw h alive on Mar 28, 19 29,

and that death occurred, on the date stated above, at 11:30 p m.

The CAUSE OF DEATH* was as follows:

1a Nephritis 3. Hypertension

1b Myocarditis

1c Aortitis

(duration) 1 yrs. 1 mos ds.

CONTRIBUTORY (Secondary): Acute cardiac dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical data

(Signed) T. Scheeng, M. D.

, 19 (Address) 304 E Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: April 1 29

20 UNDERTAKER: Edward W. Conklin — ADDRESS: 927 E Eager St

TION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 44558

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44558

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 1-24 Ward)

REGISTERED NO. 188-403

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John J. Greacen

(a) RESIDENCE NO. 851 Holmes Ter Ferry Ste Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lena M. Greacen

6 DATE OF BIRTH (month, day, and year) Feb. 21, 1885

7 AGE Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
44	1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work had worked as [illegible]

(b) General nature of industry, business, or establishment in which employed (or employer) Shipping Clerk

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER John Greacen

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Elda Shealy

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto Co Md.

14 Informant Mrs. Lena M. Greacen

(Address) 851 Holmes Ter Ferry Sta

Filed ..... 19 C. HAMPSON JONES, M. D.

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28. 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract. L. femur: colles fracture. perf. fract. skull - fract nasal and about 15 hours

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Hypostatic pneumonia

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) W. J. Miller M. D.

(Coroner)

March 29, 1929 (Address) 1639 Druid

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. 15 mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial New Cathedral Cemetery April 1 1929

20 UNDERTAKER Edmund W. Condon ADDRESS 924 E. Eager St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

30 1929

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44559

CERTIFICATE OF DEATH

E 44559

1-PLACE OF DEATH

City of Baltimore: (No. City Hospital St. 3-4 Ward)

2-FULL NAME William McCall

(a) RESIDENCE NO. 1325 Bond St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO. 197

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male.	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not known

6 DATE OF BIRTH (month, day, and year) Not known

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
72.			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer B. & O. Railroad

9 BIRTHPLACE (city or town) South Carolina
(State or country) S. Carolina

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) S. Carolina

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

14 Informant Sarah Cole
(Address) 1325 Bond St.

15 Filed ..... 19.... C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Homicide Gun Shot. of Skull

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Shock

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Bond & Orett.

Did an operation precede death? ..... Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) W. E. Glades, M. D.

May 29 1929 (Address) 143 N. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem.	May 29, 1929
20 UNDERTAKER	ADDRESS
Woodall & Leggett	3128 Eu

MAY 30 1929

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 44560

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

47 E 44560

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No.) Monument + Rutland (Street) April 20 (WARD)

2-FULL NAME Helen Solomon

(a) RESIDENCE NO. Marlborough Apt. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sigmund Solomon

6 DATE OF BIRTH (month, day, and year): May 2nd 1861

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
67	10	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Emanuel Fleischer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Theresa Strauss

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant: Mrs. S. Adler

(Address) Marlborough Apt.

15 Filed APR 30 1929, 19

C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 29 1929

17 I HEREBY CERTIFY, That I attended deceased from 2-25, 1929, to 3-28, 1929, that I last saw her alive on 3-28, 1929, and that death occurred, on the date stated above, at 12 20 m.

The CAUSE OF DEATH* was as follows:

Carcinoma Breast
Secondary Metastases
Hydrothorax Right.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Hydro. thorax

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) B J Cohen, M. D.

, 19 (Address) Sinai Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bnai Israels Hebrew Cem.

DATE OF BURIAL: 3/31/1929

20 UNDERTAKER: David Sondheim

ADDRESS: 118 & 120 W. Mt. Royal Ave.

TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 44561

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 44561

REGISTERED NO. 168

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2019 McCulloh St. 11-20 Ward)

2-FULL NAME Sarah E. Tynes.

(a) RESIDENCE NO. 2019 McCulloh St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of No

6 DATE OF BIRTH (month, day, and year) 1859.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs or min
	70			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Nurse,
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Boston Mass
(State or country)

PARENTS

10 NAME OF FATHER J. F. Tynes

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Sarah Hayes.

13 BIRTHPLACE OF MOTHER (city or town) Mass
(State or country)

14 Informant J. F. Tynes
(Address) 2019 McCulloh St.

15 Filed MAR 30 1929 19 Registrar C. HAMILTON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) March 29th 1929.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest find that said deceased came to death (Inquest, autopsy or inquiry) on the day stated above.
The CAUSE OF DEATH* was as follows:
(Suicide) Strangulation Hung herself.
(duration) yrs. Sudden

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 2019 McCulloh
Did an operation precede death? No Date of
Was there an autopsy? No.
What test confirmed diagnosis? Regular
(Signed) Hoffman, M. D.
(Address) March 29th 1929 Coroner.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Boston, Mass. DATE OF BURIAL 3/30/1929

20 UNDERTAKER Miss. Geo. H. Holland ADDRESS 1631 Druid Hill Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44562

CERTIFICATE OF DEATH.

44 E 44562

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Franklin Square Hospital (St.) 15-58 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Simon Wiernik

(a) RESIDENCE No. 3404 Hillsdale Place ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs. mos. ds. (If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 ~~Single, Married, Widowed,~~ or Divorced, (~~write the word~~) ~~Widowed~~

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Wiernik

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE: 61 Years — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Hirsh Wolf Wiernik

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rubinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jack Lewis 1439 E. Balto St

15 Filed MAR 31 1929 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/30 1929

17 I HEREBY CERTIFY, That I attended deceased from 3/28, 1929, to 3/30, 1929, that I last saw him alive on 3/30, 1929, and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Dr Victor Goldberg, M. D.

3/30 1929 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Hebrew Rom — DATE OF BURIAL: 3/31 1929

20 UNDERTAKER: Jack Lewis 1439 E. Balto St — ADDRESS

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44563

CERTIFICATE OF DEATH.

90

E 44563
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 115 N. Pine St. St. 4-25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herman Schiller

(a) RESIDENCE NO. 115 N. Pine St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. — mos. — ds. How long in U. S., if of foreign birth? 37 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Bessie Schiller.

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	44	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work tailor

(b) General nature of industry, business, or establishment in which employed (or employer) tailoring

(c) Name of employer self

9 BIRTHPLACE (city or town)

(State or country) Russia

PARENTS

10 NAME OF FATHER Louis Schiller

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Marie Rotman

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant David Schiller

(Address) 115 N. Pine St.

15 Filed ..... 19 .....

APR 3 1929

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29, 1929

17

I HEREBY CERTIFY, That I attended deceased from May 1, 1924, to March 29, 1929, that I last saw him alive on March 29, 1929, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Acute cardiac dilatation

(duration) — yrs. — mos. 6 ds.

CONTRIBUTORY (Secondary) Chronic Valvular heart disease over 5 years

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Henry A. Ohler M. D.

3-30, 1929 (Address) 1203 W. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Kehrem Rosedale — Date of Burial 3/31 1929

20 UNDERTAKER Jack Lewis ADDRESS 1439 E. Baltimore St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44564
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

X 89 V

25-77

E 44564
REGISTERED NO.

City of BALTIMORE: (No. 1301 Patapsco Ave. Curtis Bay St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Thomas E. Collins.

(a) RESIDENCE NO. 1301 Patapsco Ave. Curtis Bay St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 1 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower.

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Sarah Collins.

6 DATE OF BIRTH (month, day, and year) March 7, 1869

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	60	0	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cabinet maker.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Vienna Md.

PARENTS

10 NAME OF FATHER Elijah Collins.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Do not know.

14 Informant Ross E. Collins. (son)

(Address) 1301 Patapsco Ave. Curtis Bay.

Filed MAR 31 1929 C. HAMPSON JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28, 1929. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris.

Obstruction of the Coronary Arteries.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Robert Brooks M. D. (Coroner)

3/30 19 29 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem

Date of Burial 4-1 1929

20 UNDERTAKER Robert Brooks & Son

ADDRESS Eutaw & Fallsway

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-27 —A Co.—200 Bks.

E 44565

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

182 E 44565

REGISTERED NO.

1-PLACE OF DEATH Founder water

City of BALTIMORE: (No. ~~Fort~~ 7 E Falls ave St. 6-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martin Chesser

(a) RESIDENCE NO. 143 N Patterson Pk ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nancy Chesser

6 DATE OF BIRTH (month, day, and year) ×12-9-1866

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
×	62	3	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ship Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) 015

(c) Name of employer Government

9 BIRTHPLACE (city or town)

(State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Mr. Chesser

(Address) 143 N Patterson Pk

Filed APR 31 1929 H. HANSON JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 28 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(duration) Sudden yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) James A Fenton, M. D.

(Coroner)

3 29 1929 (Address) 708 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Londer Pk Cem — Date of Burial 4/1 1929

20 UNDERTAKER J. Frew McCully — ADDRESS 130 E. Fort

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 44566 ? 2250

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 ✓ E 44566

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 16-22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Nina Daley

(a) RESIDENCE NO. 208 Mosher ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (~~write~~ the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Leroy Daley

6 DATE OF BIRTH (month, day, and year): June 30 1898

7 AGE: Years 30 | Months 8 | Days 29 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home Wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: John Fenn

11 BIRTHPLACE OF FATHER (city or town) (State or country): North Carolina

12 MAIDEN NAME OF MOTHER: Bertha Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Friends

(Address):

15 Filed ... 19 ... (Signature) ... Registrar

R 31 1929 W. H. SANG ROSA

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 29 1929

17 I HEREBY CERTIFY, That I attended deceased from March 22, 1929, to March 29, 1929, that I last saw h[illegible] alive on March 29, 1929 and that death occurred, on the date stated above, at 6 15 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. F. Briggs M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Lebanon — DATE OF BURIAL: Mar 31 1929

20 UNDERTAKER: Thomas Goldsmith — ADDRESS: 1644 N. Carey

Instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Hks.

22772

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44567

CERTIFICATE OF DEATH

161-001

E 44567

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL 16-22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Muriel Crandall

(a) RESIDENCE NO. 711 N. Payson ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married,~~ ~~Widowed,~~ or Divorced. (write the word): Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 24 1929

7 AGE — Years | Months | Days: 6 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Charles Crandall

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Adelaide Townsend

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Friends
(Address)

15 [illegible] Registrar

APR 31 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30-29

17 I HEREBY CERTIFY, That I attended deceased from March 24, 1929 to March 30, 1929.

that I last saw her alive on March 30, 1929

and that death occurred, on the date stated above, at 5-45 a. m.

The CAUSE OF DEATH* was as follows:

Traumatism

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Thos. H. Cullen, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: Apl 1 1929

20 UNDERTAKER: Bertram Bros — ADDRESS: 23 W. Lafayette Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44568

CERTIFICATE OF DEATH

E 44568

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Baltimore City Hospitals (ST.) (WARD) 1725

REGISTERED NO. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Julia Leonard

(a) RESIDENCE NO. 500 block Arch st. ST., WARD

(Usual place of abode) Unknown (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry J. Messick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Lear Burch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records

(Address)

15 Filed MAR 31 1929 WM. H. JAMPOLINE, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28, 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb. 8, 1929, to March 28, 1929, that I last saw her alive on March 28, 1929 and that death occurred, on the date stated above, at 9.30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical and lab.

(Signed) Henry C. Smith, M. D.

3-28 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	4-1 1929
20 UNDERTAKER Daniel Eaton & Co	ADDRESS 946

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44569
1—PLACE OF DEATH

CERTIFICATE OF DEATH

31 E 44569
REGISTERED NO.

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST., 1632 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Gertrude Broadus (Hall)

(a) RESIDENCE NO. 1106 N. Mount st. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington Distric of Columbia

PARENTS

10 NAME OF FATHER Julius Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington D. C.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records
(Address)

15 Filed MAR 31 1929 HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 27, 19 29, to March 29, 19 29, that I last saw her alive on March 29, 19 29 and that death occurred, on the date stated above, at 3.15 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical and lab.

(Signed) Henry C. Smith, M. D.

3-29 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL 4-1-29

20 UNDERTAKER Daniel Easton — ADDRESS 916 Bond

Spec—12-23-21—E.B.R.S.—400 Bks.

E 44570 HEALTH DEPARTMENT—CITY OF BALTIMORE E 44570

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 774 W. Saratoga St., 18 Ward) Registered No. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Dyer McGowan

(a) Residence No. 774 W. Saratoga St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of Angela McGowan

6-DATE OF BIRTH (month, day and year) Unknown

7-AGE, 80 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Laborer

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), S. C.

PARENTS.

10-NAME OF FATHER, Jerry McGowan

11-BIRTHPLACE OF FATHER (city or town) (State or Country), S. C.

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Unknown

14- (Informant) Harry McGowan

(Address) Grand Rock N. J.

15- MAR 31 1929 HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). March 30 1929.

17- I HEREBY CERTIFY, That I attended deceased from March 24, 1929 to March 29, 1929 that I last saw h. alive on March 29, 1929 and that death occurred, on the date stated above, at 7.45 A. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) John D. Buttrum M. D.

3/30, 1929 (Address) 1507 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Auburn Cem. DATE OF BURIAL. April 1, 1929

20-UNDERTAKER. David Estes ADDRESS 916 5th Ave

instructions on back of certificates. See

Cor.—12-9-25—A Co.—200 Bks.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44571

CERTIFICATE OF DEATH.

90 E 44571

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1148 Leadenhall St. 23-31 St. _____ Ward)

2-FULL NAME George W. Pumphrey.

(a) RESIDENCE NO. 1116 Leadenhall St. St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. __ mos. __ ds. How long in U. S., if of foreign birth? __ yrs. __ mos. __ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice M. Pumphrey.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	69	----------		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Do not know.

14 Informant Mary L. Hooper. (daughter)

(Address) 4013 Pennington Ave.

15 Filed MAR 31 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28, 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic disease of the Heart.

(duration) __ yrs. __ mos. __ ds.

CONTRIBUTORY (Secondary) _____

(duration) __ yrs. __ mos. __ ds.

(Signed) _____, M. D. (Coroner)

3/30 1929 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death __ yrs. __ mos. __ ds. In the State __ yrs. __ mos. __ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery Date of Burial Apr 1st 1929

20 UNDERTAKER George L. Schwartz ADDRESS 1100 Hulk Ave.

Spec.—2-29-28—L. F. S.—500 Bks.

223399
E 44572

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

57 E 44572

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 21-53 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Mullen

(a) RESIDENCE NO. 203 Ridgewood Rd ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Michael

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Winifred Queredy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Records

(Address)

15 Filed 3 1 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30-1929

17 I HEREBY CERTIFY, That I attended deceased from March 14, 1929, to March 30, 1929, that I last saw h[illegible] alive on March 30, 1929 and that death occurred, on the date stated above, at 4 55 A m.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus - Infection Antrum - Death unexplained

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Drainage Sinus — Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine - + M -

(Signed) Blue Chemistry — M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	Apr. 3 1929
20 UNDERTAKER	ADDRESS
George L. Schwab	1301 Eutaw Ave

Spec.—2-29-28—L. F. S.—500 Bks.

E 24 44573 — HEALTH DEPARTMENT—CITY OF BALTIMORE — E 44573

CERTIFICATE OF DEATH X 49

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Luietta Watson

(a) RESIDENCE NO. Athens Ga ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	sgle

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 2 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	9	8	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child · School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) La

PARENTS

10 NAME OF FATHER John Watson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ga

12 MAIDEN NAME OF MOTHER Minnie Jordon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ga

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 4-1-1929 19 C. HAMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30-1929

17 I HEREBY CERTIFY, That I attended deceased from March 29. 1929. to March 30. 1929, that I last saw her alive on March 30, 1929 and that death occurred, on the date stated above, at 11 50 P. m.

The CAUSE OF DEATH* was as follows:

Tumor of the pineal Gland.

Malignant

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Operation 3-30-29

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 3-30-29

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) I Ridgeway Taylor M. D.

March 31, 1929 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Arcadia La

DATE OF BURIAL April 1 1929

20 UNDERTAKER John Merrick

ADDRESS 2108 Eutaw

Spec.—1-12-23—M&T—500 Blks.

E 44574 HEALTH DEPARTMENT—CITY OF BALTIMORE E 44574

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Chas. St. Ave. + Cold Spring Lane (St.) (Ward) 164

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Griffith Crocker

(a) RESIDENCE No. Chas St Ave + Cold Spring Lane (St.) WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Letitia Crocker

6 DATE OF BIRTH (month, day, and year): Aug 14 - 1843

7 AGE: Years 85 | Months 7 | Days 15 | If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Grain Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Emmanuel Crocker

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Harriett Griffith

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address): Letitia Crocker Chas St Ave + Cold Spring Lane

15 Filed APR 1 1929 C. HAMPSON JONES, M. D. Registrar

Reg. City

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 29 - 1929

17 I HEREBY CERTIFY, That I attended deceased from 10-2 . 1928 to 3-29 . 1929 that I last saw him alive on 3-28 . 1929 and that death occurred, on the date stated above, at 1 a. m

The CAUSE OF DEATH* was as follows:

Senile Pneumonia

CONTRIBUTORY (Secondary) Locomotion (duration) yrs. 6 mos ds.

(duration) yrs 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Arthur F. Barrett, M. D.

(Address) 2000 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: April 1 1929

20 UNDERTAKER: Chas. S. Braun & Son — ADDRESS: 118 W. Mt. Royal Ave

TION is very important See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 44575

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44575

CERTIFICATE OF DEATH

x 31

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 4-7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Norman Lawman

(a) RESIDENCE NO. Woodbine, Md. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	Black	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elvina Lawman

6 DATE OF BIRTH (month, day, and year) Sept. 6 1905.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	23	6	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md

PARENTS

10 NAME OF FATHER John M Lawman

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland,

12 MAIDEN NAME OF MOTHER Fannie Berry

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland.

14 Informant Lewis Lawman

(Address) 511 Mosher St. Balto.

15 Filed C. HAMPSON JONES, M. D. Registrar

PRT - 1929 Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/30/29 19

17 I HEREBY CERTIFY, That I attended deceased from 2/6/29, 19, to 3/30/29, 19, that I last saw h/ alive on 3/30/29 19, and that death occurred, on the date stated above, at 5 45 a.m. m.

The CAUSE OF DEATH* was as follows:

1 Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis Pneumonia

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. S. Hammond, M. D.

3/30, 1929 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Carroll Co. Md. White Rock Cemetery — Date of Burial Apr. 2 1929.

20 UNDERTAKER C. M. Waltz — ADDRESS Westfield, Md.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

23. E 44576

E 44576

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital 15-60 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Louis Howe

(a) RESIDENCE NO. 1626 Ashburton ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 8 mos. 23 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 7, 1926

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2	8	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER Francis Howe

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md
(State or country)

12 MAIDEN NAME OF MOTHER Marie Sawyer

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant Marie Howe

(Address) 1626 Ashburton St.

Filed MAR 1 1929, 19 — C. HAMILTON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30 1929.

17 I HEREBY CERTIFY, That I attended deceased from March 27, 1929. to March 30, 1929.

that I last saw him alive on March 30, 1929

and that death occurred, on the date stated above, at 7:45 a. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lethargic Encephalitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1626 Ashburton St

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Addison Craft Clark, M. D.

3-30, 1929 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem.	April 1, 1929.
20 UNDERTAKER	ADDRESS
J. J. Cowan & Son.	401 Hollins

Important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 44577 HEALTH DEPARTMENT—CITY OF BALTIMORE **E 44577**

CERTIFICATE OF DEATH.

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1322 W. Lexington ST. (WARD) 19-26

2-FULL NAME Harry J. Riebling

(a) RESIDENCE NO. 1322 W. Lexington ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced. (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie E. Riebling

6 DATE OF BIRTH (month, day, and year) Dec 2. 1874

7 AGE Years 54 Months 3 Days 27

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Lentz & Trust Co

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER George Riebling

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Seifert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Annie E. Riebling

(Address) 1322 W. Lexington St

15 Filed R 1 - 1929 By C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 16, 1928, to March 29, 1929, that I last saw him alive on March 23, 1929, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis + Mitral Regurgitation,

(duration) One yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac dilatation,

(duration) yrs. Sudden mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual -

(Signed) M Bernard Strouse, M. D.

3/30, 1929 (Address) 626 N. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore

DATE OF BURIAL 4/1 19 29

20 UNDERTAKER J. H. Cook

ADDRESS 1218 Eutaw St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

Lindeman

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44578

CERTIFICATE OF DEATH

89

E 44578

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 521 Nottingham Road ST. 28-71 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Lindeman

(a) RESIDENCE NO. 521 Nottingham Road ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of August Lindeman

6 DATE OF BIRTH (month, day, and year) Dec. 19, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	3	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Bernhardt Kepper

11 BIRTHPLACE OF FATHER (city or town) Bavarian
(State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine (Unknown)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mr. Arthur Siegk

(Address) 521 Nottingham Road

Filed APR 1 1929 C. HAMPSON JONES, M. D. Registrar

Per [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1928 to March 28 1929, that I last saw her alive on March 28, 1929 and that death occurred, on the date stated above, at 8.10 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) 1 Hour

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Eugene L. Pessano M. D.

3.29.1929 (Address) Ten Hills 514 Dromedan

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cemetery

DATE OF BURIAL April 1 19 29

UNDERTAKER J. R. Cook

ADDRESS 1003 West Baltimore St

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 44579

E 44579

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 60 Woodbourne Ave ST., 7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary E. Barner

(a) RESIDENCE NO. 60 Woodbourne Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Barner.

6 DATE OF BIRTH (month, day, and year) April 4 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	11	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Newark Md

PARENTS

10 NAME OF FATHER James McNear

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) [illegible]

14 Informant Mrs Mary Smith

(Address) 60 Woodbourne Ave

15 Filed APR 1 1929, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb 24, 1929, to March 30, 1929, that I last saw her alive on March 30, 1929, and that death occurred, on the date stated above, at 7.20 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency -

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinomatosis (Generalized)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Henry Weinstock, M. D.

3/31, 1929 (Address) 1730 E Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem

DATE OF BURIAL April 2 1929

20 UNDERTAKER W. L. B. Cook

ADDRESS 1003 W Balt St

Important. See instructions on back of certificates.

Spec.—12-9-28—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44580

CERTIFICATE OF DEATH.

E 44580

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) Church Home & Infirmary St., (Ward)

2-FULL NAME Mary Emma ~~Emma F.~~ Lane

(a) RESIDENCE NO. 152 Filson St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. 0 mos. 27 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced (or) WIFE of: Chas. Walcott Lane

6 DATE OF BIRTH (month, day, and year): Oct. 1, 1868

7 AGE — Years: 60 — Months: 5 — Days: 27 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Balto

(State or country): Md.

PARENTS

10 NAME OF FATHER: Henry Kyle

11 BIRTHPLACE OF FATHER (city or town): Balto

(State or country): Md.

12 MAIDEN NAME OF MOTHER: Virginia Pickton

13 BIRTHPLACE OF MOTHER (city or town): Balto

(State or country): Md.

14 Informant: Mr. Charles H. Lane

(Address) 152 Filson St

15 Filed APR 1 1929 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 27, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 12, 1929, to March 27, 1929, that I last saw h.....alive on March 27, 1929, and that death occurred, on the date stated above, at 9:20 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Myocardial Insufficiency

(duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) 1 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) James H. Norris Jr., M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem. Date of Burial: Apr 1 1929

20 UNDERTAKER: Wm. Tucker Sons ADDRESS North & Pa

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44581

CERTIFICATE OF DEATH

109-002

E 44581

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Md. Gen. Hosp. St. 15-65 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary L. Young

(a) RESIDENCE NO. 3743 Portoma Rd SW Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Alan S. Young

6 DATE OF BIRTH (month, day, and year): Dec 30, 1889

7 AGE — Years: 39 Months: 2 Days: 29 IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home wife

(b) General nature of industry, business, or establishment in which employed (or employer): at home.

(c) Name of employer

9 BIRTHPLACE (city or town): Philadelphia

(State or country): Penn.

PARENTS

10 NAME OF FATHER: Jacob K. Lessig

11 BIRTHPLACE OF FATHER (City or town)

(State or country): New Jersey

12 MAIDEN NAME OF MOTHER: Ellie Harris

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): New Jersey

14 Informant: Hosp. Records.

(Address)

15 Filed 4-19 1929 By HAMPSON JONES, M. D. Registrar

For Robt

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

Mar 1, 1929.

17 I HEREBY CERTIFY, That I attended deceased from 3-27- 1929, to 3-29- 1929.

that I last saw her alive on 3-29- 1929.

and that death occurred, on the date stated above, at 5:00 P m.

The CAUSE OF DEATH* was as follows:

Agranulocytic angina

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary): Streptococcus septicemia

(duration) yrs. mos. 2 1. ds.

18 Where was disease contracted

if not at place of death? At home.

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinical & path.

(Signed) Jno A Jamison M. D.

3/29/29 (Address) Md Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cremation, London Park Apr 1 1929

Date of Burial

20 UNDERTAKER: J. J. Tickner & Sons

ADDRESS: Balto

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

R 1-1929

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 44582

1-PLACE OF DEATH

City of Baltimore: (No. 1576 Baker St. 15-21 Ward)

2-FULL NAME Mary E. Nickens

(a) RESIDENCE NO. 1576 Baker St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 mos. 14 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

101-001

E 44582

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of No

6 DATE OF BIRTH (month, day, and year) Jan 17-1929

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
		2	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Wm Nickens

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Mary Walker

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Mary Nickens
(Address) 1576 Baker

15 Filed APR 1 - 1929 19 Registrar HARRISON JONES M. D.
By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to [illegible] death on the day stated above.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) [illegible] M. D.
(Address) March 31 1929 Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn cemetery	April 1 1929
20 UNDERTAKER	ADDRESS
Thomas E. Kelson	1303 Pressman

DIRECTIONS TO PHYSICIAN, CORONER AND UNDERTAKER

Fill out all items carefully and in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 44583 (1-PLACE OF DEATH)

E 44583 REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of Baltimore: (No. Provident Hosp St., 15-21 Ward)

2-FULL NAME Social Fenwick

(a) RESIDENCE NO. 1423 N. Mont St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of No.

6 DATE OF BIRTH (month, day, and year) Dec - 1928.

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
	3	-	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country)

PARENTS

10 NAME OF FATHER William Fenwick

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Viola Dorsey

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Provident Hosp. Record.
(Address) Baltimore, Md.

Filed APR 1 - 1929 WILLIAM H. JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) March 31 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Cerebral Meningitis

(duration) yrs. mos. Hrs.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of Mar 31

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) F. C. Fenwick, M. D.

March 31st 1929 (Address) Coroner.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cemetery	April 1 1929
20 UNDERTAKER Thomas E. Kelson	ADDRESS 1303 Pennsylvania

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.--2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44584 E 44584

CERTIFICATE OF DEATH

101-001

1—PLACE OF DEATH

REGISTERED NO. 1623

CITY OF BALTIMORE: (No. 924 Harlem Ave. St., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lucia Barnes

(a) RESIDENCE NO. 924 Harlem Ave. St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Col	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alexander Barnes

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Ø

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant John Barnes

(Address) Christ's Church P.O. Va

15 Filed 1-1929 C. HARRISON JONES, M. D. Registrar

Rec'd

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31 1929

17 I HEREBY CERTIFY, That I attended deceased from March 23, 1929, to March 31, 1929, that I last saw h.. alive on March 30, 1929 and that death occurred, on the date stated above, at 10:30 a.m.

The CAUSE OF DEATH* was as follows: Pneumonia Lobar

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Characteristic Symptoms

(Signed) C. H. Flowe M. D.

March 31 1929 (Address) 714 Hond Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL April 1 1929

20 UNDERTAKER Wm. H. Chase & Son — ADDRESS 1400 Mother

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44585

CERTIFICATE OF DEATH

46

E 44585

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1305 E. Northern ST., 9-18 WARD)

2—FULL NAME Katherine Amelia Gude

(a) RESIDENCE NO. 1305 E. North Ave. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Frederick G. Gude

6 DATE OF BIRTH (month, day, and year) Mar. 21-1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60		9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Otto Lower

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Friede

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Fredk. G. Gude

(Address) 1305 E. North Ave

15 Filed 1-1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30-1929

17 I HEREBY CERTIFY, That I attended deceased from Feb, 1926, to Mar 30, 1929, that I last saw her alive on March 26, 1929 and that death occurred, on the date stated above, at 8.40 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cervix

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of Jan-1926

Was there an autopsy? no

What test confirmed diagnosis? Microscopic Exam.

3/30 1929 (Signed) Charles Reid Edwards M. D.

(Address) Medical Arts Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Emmanuel Cemetery	April 3 1929
20 UNDERTAKER Henry Lutz	ADDRESS 1203 N. Broadway

Spec.—1-12-23—M&T—500 Bks.

E 44586 HEALTH DEPARTMENT—CITY OF BALTIMORE E 44586

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2826 Laurens ST., 16-6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Ann Marriott

(a) RESIDENCE NO. 2826 Laurens ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. 7 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of: The late John Massey Marriott

6 DATE OF BIRTH (month, day, and year): Aug 9th 1853

7 AGE — Years: 75 Months: 7 Days: 20 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Henry Guy Schrote

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Elizabeth Reisinger

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant (Address): John Nelson Marriott 119 Massachusetts Ave NW D.C.

15 Filed Mar 31 1929 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar 29th 1929

17

I HEREBY CERTIFY, That I attended deceased from Mar 27, 1929, to Mar 29, 1929, that I last saw him alive on Mar 29, 1929, and that death occurred, on the date stated above, at 145 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Oedema of Lungs, Ascites

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home of Death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys Exam

(Signed) John L. Thaland, M. D.

3/30, 1929 (Address) 1219 Poplar Grove St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: 4/2, 1929

20 UNDERTAKER: Geo. Nelson & Son — ADDRESS: 2503 Edmondson Ave

Form A very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44587

CERTIFICATE OF DEATH.

74001

E 44587

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1620 Harlem av St., 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eah Dennis

(a) RESIDENCE NO. 1620 Harlem av St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Geo. Dennis

6 DATE OF BIRTH (month, day, and year): 1874

7 AGE: Years 55 | Months — | Days — | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Dorchester Co. Md.

(State or country)

PARENTS

10 NAME OF FATHER: Andrew Jackson

11 BIRTHPLACE OF FATHER (city or town): Md.

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Md

14 Informant: Margaret A Hall

(Address) 1620 Harlem Ave

Filed 1929 H. HAMPSON JONES, M. D., Registrar

Ref

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/29 1929

17 I HEREBY CERTIFY, That I attended deceased from Mar. 22, 1929, to Mar. 29, 1929, that I last saw h.e alive on Mar. 29, 1929, and that death occurred, on the date stated above, at 10:20 m.

The CAUSE OF DEATH* was as follows:

Auto Sepsis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage about

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Physical

(Signed) John H Tompkins, M. D.

3/30 1929 (Address) 1012 N. Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Calvery Cem — Date of Burial: 4-2 1929

20 UNDERTAKER: Byron Wright — ADDRESS: 1218 McElderry St

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 44588

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129

E 44588 REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 926 Ausgusta ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alfred Thomas

(a) RESIDENCE NO. 926 Ausgusta ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	C.	M

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Jannie Thomas

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Caulker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER David Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Stephen H. Thomas Son

(Address) 926 Ausgusta St

15 Filed APR 1 - 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec, 1928, to March 29, 1929, that I last saw him alive on March 27, 1929 and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

& Generalized Anasarca

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency and Hypertension (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Q. F. Young, M. D.

3/30, 1929 (Address) 1429 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cem

DATE OF BURIAL 4-1- 1929

UNDERTAKER Byron Wright 1218 E Eldersley

ADDRESS

Spec.—2-29-28—L. F. S.—500 Bks.

E 44589

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

45

REGISTERED NO. E 44589

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 152 N. Luzerne ave ST. 6-10 WARD)

2—FULL NAME George J. Strickrath

(a) RESIDENCE NO. 152 N. Luzerne ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie Strickrath

6 DATE OF BIRTH (month, day, and year) Jan 5 1886

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
43	2	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER John Strickrath

11 BIRTHPLACE OF FATHER (city or town) Ger.
(State or country)

12 MAIDEN NAME OF MOTHER Mary K. Weis

13 BIRTHPLACE OF MOTHER (city or town) Ger.
(State or country)

14 Informant Mrs. Carrie Strickrath
(Address) 152 N. Luzerne

15 Filed 1929 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29 1929.

17 I HEREBY CERTIFY, That I attended deceased from January 14, 1929, to March 29, 1929, that I last saw him alive on March 24, 1929 and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Retroperitoneal Sarcoma

(duration) yrs. 7½ mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? usual

(Signed) [illegible], M. D.

3/30, 1929 (Address) 110 E Hoffman

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	April 2 1929
20 UNDERTAKER	ADDRESS
Jos. J. Herr	156 N. Luzerne ave.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44590

CERTIFICATE OF DEATH.

74-02

E 44590

REGISTERED NO.

1-PLACE OF DEATH Mercy Hospital

City of BALTIMORE: (No. St 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nick Sorkos

(a) RESIDENCE NO. 1010 E Lexington St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Greece

PARENTS

10 NAME OF FATHER Wm Sorkos

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Greece

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Greece

14 Informant Sorkos

(Address) 1010 E Lexington St

15 Filed APR 1 - 1929 L. HAMILTON JONES Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-31-1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac hemorrhage.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Carbon Monoxide Poisoning

(duration) yrs. mos. ds.

3-31-29 (Signed) H. J. Pitts M. D.

(Coroner)

, 19 29 (Address) 1637 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem Date of Burial 4-3-1929

20 UNDERTAKER Robert Brooks & Son ADDRESS Cathedral Holliday

Of DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

2-23865

E 44591 HEALTH DEPARTMENT—CITY OF BALTIMORE E 44591

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 1-10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Theresa Lambert

(a) RESIDENCE NO. 505 N. Carl st ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W.	Mar

a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Lambert

6 DATE OF BIRTH (month, day, and year) Feb 10 - 1907

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H.W.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Philip Funsline

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Florence Blessing

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Friends

(Address) JOHNS HOPKINS HOSPITAL

15 Filed APR 1 - 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31-1929

17 I HEREBY CERTIFY, That I attended deceased from March 29, 1929, to March 31, 1929, that I last saw h alive on March 31, 1929 and that death occurred, on the date stated above, at 3.58 A m.

The CAUSE OF DEATH* was as follows:

Eclampsia

CONTRIBUTORY (Secondary) Pregnancy - term. (duration) yrs. mos. 3 ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? Yes -

What test confirmed diagnosis?

(Signed) E. W. Harrison Jr M. D.

, 19 (Address) John Hopkins Hosp -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery — DATE OF BURIAL April 3 1929

20 UNDERTAKER Geo C. Miller & Son ADDRESS 2334 Jefferson

Cor.—10-10-29—A Co.—100 Bks.

E 44592

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 44592

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 920 N. Montford Ave St., 7-13 Ward)

2-FULL NAME Charles Bolek

(a) RESIDENCE NO. 920 N. Montford Ave St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	white	widower

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Anna Bolek

6 DATE OF BIRTH (month, day, and year) Aug 24/1004

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	04	7	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Germany

PARENTS

10 NAME OF FATHER John Bolek

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Mrs. Jary Mack
(Address) 920 N. Montford

15 Filed APR 1 - 1929 WILLIAMSON JONES, M. D. Registrar
By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to d.i.b. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) General Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Inquiry

(Signed) J. C. Bolek, M. D.

4/1/29 (Address) 506 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem — DATE OF BURIAL April 2 1929

20 UNDERTAKER George W Zirkin — ADDRESS 1737 Eager St.

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

E 44593 HEALTH DEPARTMENT—CITY OF BALTIMORE E 44593

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 838 Edmondson Ave. WARD) 6-26

2-FULL NAME Lillian Franklin

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 838 Edmondson Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 15, 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pittsburgh Penna

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) " "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Richmond Va

14 Informant. Wm Franklin

(Address) 838 Edmondson Ave

15 Filed 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29. 1929

17 I HEREBY CERTIFY, That I attended deceased from 3/11, 1929, to 3/29, 1929, that I last saw her alive on 3/29, 1929, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage Pleurisy Pneumonia Influenza Lobar Pneumonia Acute Hemorrhagic Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 22 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) A. Lee Ellis, M. D.

3/29. 1929 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary Cemetery

DATE OF BURIAL 4/1 1929

20 UNDERTAKER Walter B. Prigg

ADDRESS 3910 Hamburg St

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44594

CERTIFICATE OF DEATH

47

E 44594

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1228 E. North Ave. ST. 9-18 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Elizabeth Smith

(a) RESIDENCE NO. 1228 E. North Ave ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 23, 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dress Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Christian Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Margaret Conway

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Miss Annie Smith
(Address) 1228 E. North Ave

15 Filed 1 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29 29

17 I HEREBY CERTIFY, That I attended deceased from May 0, 19 29, to June 29, 19 29, that I last saw h[illegible] alive on June 29, 19 29 and that death occurred, on the date stated above, at 5.20 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Concussion

Compound fracture right Femur

(duration) 2 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? Yes Date of May 6/29

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

4/1, 1929 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral — DATE OF BURIAL: Cem 2, 1929

20 UNDERTAKER: Rita Niedefeld — ADDRESS: 914 Fremont Ave

Spec.—2-29-28—L. F. S.—500 Bks.

E 44595 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

† 129

E 44595

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 4 30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary E. McCarthy

(a) RESIDENCE NO. 265 Hanover St. ST. Annapolis Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Feval	White	Married

5a If married, widowed, or divorced (or) WIFE of John L McCarthy

6 DATE OF BIRTH (month, day, and year) Feb 8 † 1886

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
43	1	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Massachusetts

PARENTS

10 NAME OF FATHER Robert Lonergan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary Ennright

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant John L McCarthy

(Address) Annapolis Md

15 Filed ..... 19 ..... Registrar

HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1 29

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1929, to April 1, 1929

that I last saw h.. alive on April 1, 1929

and that death occurred, on the date stated above, at 4 15 A m.

The CAUSE OF DEATH* was as follows:

Chronic Cardiovascular renal disease & hypertension

Several years (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure

about (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) W. H. Voorhees, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Novel cemetery annapolis	April 2 1929
20 UNDERTAKER B L Hopkins	ADDRESS Annapolis Md

Spec.—2-29-28—L. F. S.—500 Bks.

E 44596 HEALTH DEPARTMENT—CITY OF BALTIMORE **E 44596**

100-09

CERTIFICATE OF DEATH

BALTIMORE CITY HOSPITALS

1—PLACE OF DEATH [redacted] REGISTERED NO. .....

CITY OF BALTIMORE: (No. ..... ST. 6-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie Hart

(a) RESIDENCE NO. 1907 Lamley ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
79	78			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Maryland (State or country)

PARENTS

10 NAME OF FATHER Martin Wills

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Jane ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records of (Address) BALTIMORE CITY HOSPITALS

15 Filed [illegible] 19 [illegible] HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28, 1929

17 I HEREBY CERTIFY, That I attended deceased from February 4, 19 29, to March 28, 19 29, that I last saw her alive on March 28, 19 29 and that death occurred, on the date stated above, at 3:45 A. m.

The CAUSE OF DEATH* was as follows: Broncho-pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no What test confirmed diagnosis? Physical Exam

(Signed) John E. Moran, M. D.

19 BALTIMORE CITY HOSPITALS (Address) [redacted]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	April 1 1929
20 UNDERTAKER Edward Bryan	ADDRESS 1631 orleans st

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44597

101-001

CERTIFICATE OF DEATH

REGISTERED NO. E 44597

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 923 N. Madeira ST., 7-17 WARD)

2—FULL NAME William Frank Boresevic

(a) RESIDENCE NO. 923 N. Madeira ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. 17 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Infant

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 14, 1928

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		6	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Michael Boresevic

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Louise Stach

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Echo - Slovakia

14 Informant Michael Boresevic
(Address) 923 N. Madeira St.

15 Filed 1929 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1, 1929

17 I HEREBY CERTIFY, That I attended deceased from Mar. 16, 1929, to April 1, 1929, that I last saw h im alive on April 1, 1929, and that death occurred, on the date stated above, at 3 15 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) Vincent D. Foster M. D.

. 19 (Address) 845 N. Fond St. P K Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Apl 3 19 29
20 UNDERTAKER	ADDRESS
Frank Grack & Son	1706 Eastern Ave

Spec.—2-29-28—L. F. S.—500 Blks.

Twibles ✓ D. 44598

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001

E 44598

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 818 McDonough ST., 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Henry Twibles

(a) RESIDENCE NO. 818 McDonough ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M | 4 COLOR OR RACE C | 5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 22, 1929

7 AGE Years | Months | Days 38 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Willie Twibles

11 BIRTHPLACE OF FATHER (city or town) (State or country) S Carolina

12 MAIDEN NAME OF MOTHER Mary Boykins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Willie Twibles

(Address) 818 McDonough

15 Filed APR 1 - 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 30 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb 22, 1929 to Mar 30, 1929 that I last saw him alive on March 30, 1929 and that death occurred, on the date stated above, at 9.30 P m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 1 wk da.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

3-31, 1929 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary

DATE OF BURIAL April 1 1929

20 UNDERTAKER Wm. P. G. Elliott

ADDRESS 1725 Eastlander

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44599 **E 44599**

CERTIFICATE OF DEATH

REGISTERED NO. 90

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1140 N. Fulton Ave. ST. 16-22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie A. Jones

(a) RESIDENCE NO. 1140 N. Fulton Ave. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of late John P. Jones

6 DATE OF BIRTH (month, day, and year) Feb. 17, 1863

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
66	1	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Oliver Watts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sophia Weller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Harry H. Jones

(Address) 504 N. Payson St.

15 Filed 4-2-1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 30-29

17 I HEREBY CERTIFY, That I attended deceased from Mar. 6, 1929, to Mar. 30, 1929, that I last saw h[illegible] alive on Mar 30, 1929 and that death occurred, on the date stated above, at 2.15 P. m.

The CAUSE OF DEATH* was as follows:

Acute nephritis

(duration) yrs. mos. 2 4 ds.

CONTRIBUTORY (Secondary) Mitral Stenosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Morley Stoag, M. D.

Apr 1 1929 (Address) 729 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL 4/2/29 19

20 UNDERTAKER Harry A. Wetzke 15-31 W Lombard St — ADDRESS

Spec.—2-29-28—L. F. S.—500 Bks.

E 44600

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-002

E 44600

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1901 Fleet ST. 2-4 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mr Nathan Miller

(a) RESIDENCE NO. 1901 Fleet ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., If foreign birth? 35 yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Lena Miller

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Furniture

(c) Name of employer

9 BIRTHPLACE (city or town) Latvia
(State or country) Russia

10 NAME OF FATHER Samuel Miller

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

PARENTS

14 Informant Dr Benj Miller

(Address) 2136 W. Baltimore St

Filed 1929 HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31, 1929

17 I HEREBY CERTIFY, That I attended deceased from March, 1928, to March, 1929, that I last saw h[im] alive on March 30, 1929 and that death occurred, on the date stated above, at 1 45 P.m.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis

CONTRIBUTORY (Secondary) Arth Cardiac Arteriosclerosis (duration) 1 yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) S. C Fetterman, M. D.

3/31. 1929 (Address) 1422 E Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Herring Run — DATE OF BURIAL March 31 1929

20 UNDERTAKER S Levinson Bro — ADDRESS 1127 E Balto St

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44601

CERTIFICATE OF DEATH.

47 **E 44601**

1-PLACE OF DEATH St. Agnes Hospital

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Caton & Wilkens Ave (Ward) 25-3

2-FULL NAME Mrs Katie Bastian

(a) RESIDENCE NO. 804 Annapolis Boulevard ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Henry

6 DATE OF BIRTH (month, day, and year) Sept 24. 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	59	6.	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Conrad Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Justini Burman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Henry Bastian
(Address) 804 Annapolis Blvd

15 Filed ... 19 ... HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-29 1929

17 I HEREBY CERTIFY, That I attended deceased from 3-19, 1929, to 3-29, 1929, that I last saw her alive on 3-29, 1929, and that death occurred, on the date stated above, at 7 10 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of left breast

(duration) 5 yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Cerebral embolism and Dem

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of 3-21-29

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Nicholas R. Borelli A.B., M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL March 1929

20 UNDERTAKER Margaret G. Flynn

ADDRESS 1432 Light St

INSTRUCTIONS ON BACK OF CERTIFICATE.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 44602

REGISTERED NO. **E 44602**

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1508 Webster St. (ST.) 24-34 (WARD)

2—FULL NAME Robert E. L. Freburger

(a) RESIDENCE NO. 1508 Webster ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna McNamee

6 DATE OF BIRTH (month, day, and year) Jan. 19. 1863

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
66	2	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mariner

(b) General nature of indnstry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Edward Freburger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto, Md.

12 MAIDEN NAME OF MOTHER Mary Theron

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto, Md.

14 Informant Mrs. Robert E. L. Freburger
(Address) 1508 Webster St.

15 Filed ....., 19.... HAMPSON JONES, Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31. 1929

17 I HEREBY CERTIFY, That I attended deceased from Mar 1, 19 29, to Mar 31, 19 29
that I last saw h alive on Mar 30, 19 29
and that death occurred, on the date stated above, at 12.52 A m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

Indefinate (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Asphyxiation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. E. L. Campbell M. D.

3/31. 1929 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem.	April 3 1929
20 UNDERTAKER	ADDRESS
Margaret L. Flynn	1422 Light St.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44603

100-001

CERTIFICATE OF DEATH

E 44603

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 109 E. Montgomery St. WARD) 12-33

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frances A. Gier

(a) RESIDENCE NO. 109 E. Montgomery ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6a If married, widowed, or divorced, HUSBAND of (or) WIFE of: (Husband) Charles A. Gier

6 DATE OF BIRTH (month, day, and year): Feb. 15, 1858

7 AGE: Years 71 | Months 1 | Days 15 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Fred. W. Hardy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Elizabeth Howard

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Carrie Gier

(Address): 109 E. Montgomery St.

15 Filed APR 1 1929, 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar. 29, 1929

17

I HEREBY CERTIFY, That I attended deceased from Mar 21, 1929, to Mar 29, 1929

that I last saw her alive on Mar 29, 1929

and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary): Bronchitis (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Hamilton, M. D.

3/30/1929 (Address) 16 Randall St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery

DATE OF BURIAL: March 19 29

20 UNDERTAKER: Margaret V. Flynn

ADDRESS: 1417 Eutaw St.

Spec.—1-12-23—M&T—500 Bks.

44604

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 44604

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 634 Colorado Ave ST. 27-53 (WARD)

2-FULL NAME Amelia B. Bortner

(a) RESIDENCE NO. 634 N. Colorado Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (Husband) of (or) (Wife) of Chas F. Bortner

6 DATE OF BIRTH (month, day, and year) June 6, 1854

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
74	9	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penna.

PARENTS

10 NAME OF FATHER Nathan Bitner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER A. J. McClenaghan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Bortner (Address) 634 N. Colorado Ave.

15 Filed R 1- 1929 S. HARRISON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb. 7, 1929, to Mar. 31, 1929, that I last saw h e alive on Mar. 31, 1929, and that death occurred, on the date stated above, at 10-20 P. m.

The CAUSE OF DEATH* was as follows:

Uremia, Uremic convulsion.

(duration) yrs. 1 mos 22 ds.

CONTRIBUTORY (Secondary) Chronic nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) M. Gibson Forte, M. D.

4/1, 1929 (Address) 422 Roland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL April 2 1929

20 UNDERTAKER P. Matalino Son

ADDRESS White Hall Md

Spec.—2-29-28—L. F. S.—500 Blks.

E 44605

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

E 44605

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1624 McKean Ave, ST 15-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Julius Blechman

(a) RESIDENCE NO. 1624 McKean ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gittel Blechman

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Ellis Blechman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Louis (Address) 1739 E Balto.

15 Filed APR 1 - 1929 HAROLD Y. JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-1-29

17 I HEREBY CERTIFY, That I attended deceased from Mar-18, 1929, to April 1-, 1929, that I last saw him alive on April 1-, 1929 and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

1 Myocardial Dis i Clot:
Bronchitis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypo Static Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Abram E. Blechman M. D.

4-1, 1929 (Address) 2700 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Lebanon

DATE OF BURIAL 4-1-1929

UNDERTAKER Jack Levin, 1739 E Balto St

ADDRESS

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44606

CERTIFICATE OF DEATH.

E 44606

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Balto Jail (ST.) (WARD)

REGISTERED NO. 161-002

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Corpsm

(a) RESIDENCE NO. 2700 Eliason ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 15 hrs ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3/30/29.

7 AGE Years Months Days

If LESS than 1 day 15 hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Wilson Corpsm

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Estatella Hampson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Wilson Corpsm

(Address) 2700 Eliason ave

15 Filed Apr 1 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/30 1929

17 I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19 ,

that I last saw h alive on , 19 ,

and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows: Atelectasis, Cerebral hemorrhage

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Autopsy findings

(Signed) Paul Thurber, M. D.

1929 (Address) West Balto General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery

DATE OF BURIAL: April 1929

20 UNDERTAKER: Chas H. Kushner

ADDRESS: Collins ave

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44607

CERTIFICATE OF DEATH.

161-001

E 44607

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 925 McDonough St. WARD 13)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Scott

(a) RESIDENCE No. 925 McDonough ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of:

6 DATE OF BIRTH (month, day, and year): 3/28/29

7 AGE — Years | Months | Days: 2 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work:

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country):

PARENTS

10 NAME OF FATHER: E Autmann

11 BIRTHPLACE OF FATHER (city or town) (State or country):

12 MAIDEN NAME OF MOTHER: Anna Scott

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pennsylvania

14 Informant: Clarence Woodfolk

(Address) JOHNS HOPKINS HOSPITAL

15 Filed APR 1 1929 S. HAMPSON JONES, M. D. Registrar

BY 3363

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/30/1929

17 I HEREBY CERTIFY, That I attended deceased from 3/28, 1929, to 3/30, 1929, that I last saw him alive on 3/30, 1929, and that death occurred, on the date stated above, at 10½ m.

The CAUSE OF DEATH* was as follows:

Premature birth and anemia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Anemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? yes

What test confirmed diagnosis? Signs & Symptoms

(Signed) Jas. R. Blake, M. D.

19 (Address) 924 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Commissioner Health.

APR 1 1929

Spec.—2-29-28—L. F. S.—500 Bks.

2 2 E 44608

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

71-001

REGISTERED NO. E 44608

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Francis Buckley

(a) RESIDENCE NO. 416 Somerset St ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word)

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years: 1 — Months: 13 — Days: 10 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md —

PARENTS

10 NAME OF FATHER John Buckley

11 BIRTHPLACE OF FATHER (city or town) (State or country) American

12 MAIDEN NAME OF MOTHER Myra Stanley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Reeds —

(Address) JOHNS HOPKINS HOSP.

Filed APR 1 - 1929 HAMPSON JONES, M. D.

Reg. 3425 Registrar

Commissioner Health

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 26 1929.

17 I HEREBY CERTIFY, That I attended deceased from Mar. 25, 1929, to March 26, 1929,

that I last saw him alive on Mar 26, 1929

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pneumococcus Meningitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Culture spinal fluid

(Signed) [illegible] M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS APR 1 - 1929

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44609

CERTIFICATE OF DEATH

44 E 44609

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 4-7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sister Mary Imelda Burford

(a) RESIDENCE NO. Mercy Hospital - St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 9/ yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, ~~Married, Widowed~~, or ~~Divorced~~, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 26, 1868

7 AGE 61 Years Months 1 Days 6 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Religious - 065

(b) General nature of industry, business, or establishment in which employed (or employer) Mercy Hospital

(c) Name of employer Sisters of Mercy

9 BIRTHPLACE (city or town)

(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Burford.

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md. Baltimore

12 MAIDEN NAME OF MOTHER Julia Goff

13 BIRTHPLACE OF MOTHER (City or town)

(State or country) Md. Baltimore

14 Informant Rev Mother

(Address) Mercy Hospital

15 APR 1 - 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4 - 1 - 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 16, 1928, to April 1, 1929, that I last saw her alive on March 31, 1929, and that death occurred, on the date stated above, at 5 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of ascending colon

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Metastatic Carcinoma of Liver.

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) J. McCarey, M. D.

4/1, 1929 (Address) Mercy Hospital -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Agnes basement Com — Date of Burial April 3 1929

20 UNDERTAKER Henry Hankins & Sons — ADDRESS Edmondson Ave

very important. See instructions on back of certificates.

...ould be made in ink, and that it may be properly classified. Exact statement of OCCUPATION is

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44610

CERTIFICATE OF DEATH

E 44610

REGISTERED NO. 10F-001

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 5101 Halden av ST. Health WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James S. Carrick.

(a) RESIDENCE NO. 5101 Halden av STREET Hamilton WARD 6
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4yr. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 15-1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	3	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steam

(b) General nature of industry, business, or establishment in which employed (or employer) Plumber.

(c) Name of employer City

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John W Carrick.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Florence Stewart.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Florence A. Henderson

(Address) 5101 Halden av

15 Filed 1-1929, 19 C. HAMPSON JONES, M. D. Registrar

Per —

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-29-1929

17 I HEREBY CERTIFY, That I attended deceased from Mar 21, 1929, to Mar 29, 1929, that I last saw him alive on Mar 29, 1929 and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Syncope

CONTRIBUTORY (Secondary) Lobar Pneumonia (duration) yrs. mos. 2 ds.

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. Hobart Keech, M. D.

Mar 29, 1929 (Address) 2502 Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore County — DATE OF BURIAL April 2. 1929

20 UNDERTAKER George F Ruck — ADDRESS 1735 Harford a

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44611

CERTIFICATE OF DEATH

74-001

E 44611

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1818 N. Bethel ST. 8-17 WARD)

2—FULL NAME Albert Aro.

(a) RESIDENCE NO. 1818 N Bethel St ST.

(Usual place of abode)

WARD

Length of residence in city or town where death occurred 4f yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, ~~Widowed, or Divorced~~, (write the word): Married

6 DATE OF BIRTH (month, day, and year): June 22 1865

7 AGE: Years 63 Months 9 Days 8 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Joshua Aro

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary N. Coleman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Carrie V. Aro

(Address) 1818 N. Bethel St

15 Filed 1-1-1929 HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3/30/29.

17 I HEREBY CERTIFY, That I attended deceased from 4/28, 1928, to 3/30/, 1929.

that I last saw him alive on 3/30/ 1929

and that death occurred, on the date stated above, at 1.45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage—

Pulmonary oedema

(duration) yrs. mos. 1 ds.

CONTRIBUTORY Chronic arteriosclerosis

(Secondary) hypertension (duration) yrs. 8 mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Horace Abner Bowden, M. D.

3/30, 1929 (Address) 1517 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore County

DATE OF BURIAL: April 2, 1929

20 UNDERTAKER: George F. Ruth

ADDRESS: 1735 Harford Ave

Spec.—1-12-23—M&T—500 Blks.

E 44612

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

E 44612

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2135 Annapolis Road ST. 25-32 WARD)

2-FULL NAME Minnie Fisher

(a) RESIDENCE NO. 2135 Annapolis Road ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 13-1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		8	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Alex Fisher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Hulda Hulda

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Lewis

(Address) 1439 E Balto

15 - 1929 C. HAMPSON JONES, M. D., Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1 1929

17

I HEREBY CERTIFY, That I attended deceased from March 31, 1929, to April 1, 1929, that I last saw her alive on April 1, 1929, and that death occurred, on the date stated above, at 8:20 A m.

The CAUSE OF DEATH* was as follows:

Right Bronchopneumonia

Arteriosclerosis Congenita (Oppenheim's disease)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Frederick S Wilkes, M. D.

4-1, 1929 (Address) Sinai Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Levy Woodlawn — DATE OF BURIAL 4-1-1929

20 UNDERTAKER Jos Lewis — ADDRESS 1439 E Balto

Spec.—2-29-28—L. F. S.—500 Bks.

E 44613

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 44613

REGISTERED NO. 37

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 127 E. Fort Ave ST. 24 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary J. Ehlers

(a) RESIDENCE NO. 127 E. Fort Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 72 yrs. 9 mos. 18 ds. How long in U. S., if foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lewis C. Ehlers

6 DATE OF BIRTH (month, day, and year) June 12 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	9	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md. (State or country)

PARENTS

10 NAME OF FATHER William Bayne

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Mary J. Campbell

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Miss Katie Ehlers

(Address) 127 E. Fort Ave

15 Filed 4-1 1929 C. HAMPSON JONES, M. D. Registrar Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-30-1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 4, 1928, to Mar 30, 1929, that I last saw her alive on Mar 30, 1929, and that death occurred, on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage

(duration) 3 yrs. 6 mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Thomas Ehlers M. D.

4-1-1929 (Address) 1 E Randall

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL 4/2 1929

20 UNDERTAKER J. Fenw. McCully

ADDRESS 130 E Fort

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44614

CERTIFICATE OF DEATH

100-001

E 44614

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 27-43 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William McIntire

(a) RESIDENCE NO. 3008 Northern Pky St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ada McIntire

6 DATE OF BIRTH (month, day, and year): September 5, 1864

7 AGE — Years: 64 Months: 6 Days: 27

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Building Manager

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: E. F. Abell Estate Co

9 BIRTHPLACE (city or town): Springfield

(State or country): Massachusetts

PARENTS

10 NAME OF FATHER: William Porter McIntire

11 BIRTHPLACE OF FATHER (City or town):

(State or country): New Hampshire

12 MAIDEN NAME OF MOTHER: Flora Smart

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Connecticut

14 Informant: Mr. Edgar F. McIntire

(Address): 3940 Third St., N.W. Washington, D. C.

15 Filed 4-1-1929 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/1/29 19

17 I HEREBY CERTIFY, That I attended deceased from 3/19/29, 19, to 4/1/29, 19.

that I last saw h[illegible] alive on 4/1/29, 19,

and that death occurred, on the date stated above, at 11:35 a.m.

The CAUSE OF DEATH* was as follows:

Carbuncle On Neck

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary): Terminal Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 3/20/29

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) J. E. Windsor, M. D.

4/1 . 1929 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — Date of Burial: April 4 1929

20 UNDERTAKER: [illegible] & Cook — ADDRESS: [illegible] West Baltimore St

very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 44615

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001

E 44615

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Baltimore City Hospitals ST., (W. B.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank Mislak (Mislack)

(a) RESIDENCE NO. 306 S. Newkirk st. (14th) ST.

(Usual place of abode) WARD

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Antone Mislak

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Anna Mislak

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Hospital Records

(Address)

15 Filed 1 1929, 19 Per C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 19, 1929, to March 29, 1929, that I last saw him alive on March 29, 1929 and that death occurred, on the date stated above, at 11.55 a. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical and autopsy

(Signed) Henry Smith, M. D.

3-30, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Of Mary	Apr. 2, 1929

20 UNDERTAKER J. W. Buzewski

ADDRESS 50 Eastern Ave

Cor.—12-9-25—A Co.—200 Bks.

Schmick.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44616

CERTIFICATE OF DEATH.

66

E 44616

1-PLACE OF DEATH

REGISTERED NO. 2435

City of BALTIMORE: (No. South Baltimore General Hospital St. (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME August Schmick.

(a) RESIDENCE NO. 1411 E. Clement St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ( )

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Russia.

PARENTS

10 NAME OF FATHER August Schmick.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia.

14 Informant Mrs. Yeamen.

(Address) 1411 E. Clement St.

15 1929 C. HAMPSON JONES, M. D.

Per Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to h.s death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) (Coroner) M. D.

4/2 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? 1411 E. Clement St. March 31, 1929

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross, a, a. Md Date of Burial April 2 1929

20 UNDERTAKER Charles L. Stevens ADDRESS 501 E. Fort Ave.

very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44617

CERTIFICATE OF DEATH

44 E 44617

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 425-W 23rd ST. 12-50 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret G McDermott

(a) RESIDENCE NO. 425 W 23rd ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed or Divorced (write the word) Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 22 1879

7 AGE Years 49 Months 5 Days 8 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Frank E Farley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Murray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant John J McDermott

(Address) 425 W 23rd St

15 Filed 1929 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30-1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 20, 1928, to March 30, 1929, that I last saw h[illegible] alive on March 29, 1929 and that death occurred, on the date stated above, at 6a m.

The CAUSE OF DEATH* was as follows:

a Carcinoma Liver

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 9/18/28

Was there an autopsy? No

What test confirmed diagnosis? X

(Signed) Chas. K. Goldsborough, M. D.

19 (Address) 2923 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Joseph's Cem. Texas Md DATE OF BURIAL 4/2 29

20 UNDERTAKER Joseph A Farley Sulton & Fayette ADDRESS

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44618

CERTIFICATE OF DEATH

E 44618

1-PLACE OF DEATH Jenkins Memorial Hospital — REGISTERED NO. 47

City of BALTIMORE: (No. 1000 Calvert Ave St. 17-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Julia L. McLean

(a) RESIDENCE NO. 234 East First St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1852

7 AGE Years: 77 Months: Days: IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Teacher

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md

PARENTS

10 NAME OF FATHER: William McLean

11 BIRTHPLACE OF FATHER (City or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Georgianna Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Jenkins Memorial Hospital (Address): Cor Calvert and E. First

15 1929 C. HAMPSON JONES, Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: April 1st 1929

17 I HEREBY CERTIFY, That I attended deceased from 3/12, 1929, to 4-1, 1929, that I last saw her alive on 3/31/29, 1929, and that death occurred, on the date stated above, at 5 30 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast (Right)

(duration) 2 yrs. mos. da.

CONTRIBUTORY (Secondary) General Carcinomatosis

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) W. W. Emerson M. D.

. 19 (Address) St. Agnes Hosp Balt.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Philadelphia Pa — Date of Burial: 4/3 1929

20 UNDERTAKER: Empie & Finley — ADDRESS: Fulton & Fayette

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

(Edward Blaney) ✓

E 44619 HEALTH DEPARTMENT—CITY OF BALTIMORE E 44619

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hosp. (ST.) 3-59 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward Blaney.

(a) RESIDENCE NO. 2578 Druid Park Drive ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of Emma Blaney

6 DATE OF BIRTH (month, day, and year) Feb 8 - 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	1	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Sam. Blaney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Margaret Hylton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mrs. J. Blaney

(Address) 2-20 E 21st St

15 Filed 1929 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/30 1927

17 I HEREBY CERTIFY, That I attended deceased from 3/27, 1927, to 3/30, 1927, that I last saw h[illegible] alive on 3/30, 1927, and that death occurred, on the date stated above, at 5:20 A m.

The CAUSE OF DEATH* was as follows:

Bilateral lobar pneumonia

empyema - left.

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? Physical exam. autopsy

(Signed) A. A. Gibbs, M. D.

, 19 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Catholic Cemetery

DATE OF BURIAL April 2 1929

20 UNDERTAKER J. Harry Mc Mayfield

ADDRESS 501 E 22nd St

Spec.—2-29-28—L. F. S.—500 lbs.

E 44620 HEALTH DEPARTMENT—CITY OF BALTIMORE **E 44620**

CERTIFICATE OF DEATH 129

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 402 S. Collins Ave. ST. 20-71 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Bertha Elizabeth Miller

(a) RESIDENCE NO. 402 S. Collins Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced WIFE of Late Augustus Miller

6 DATE OF BIRTH (month, day, and year) June 24, 1850

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
78	9	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Berlin, Germany

PARENTS

10 NAME OF FATHER Rhein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary E. Miller

(Address) 402 S. Collins Ave.

15 Filed 4-1-1929, 19 Pat ACH Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-30-29

17 I HEREBY CERTIFY, That I attended deceased from Aug, 1927, to 3-30, 1929, that I last saw her alive on 3-29, 1929, and that death occurred, on the date stated above, at 5:30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Hypertension

Cardiac Fibrilation

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Arrhythmia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Edl Wrenn, M. D.

4/1/, 1929 (Address) 4006 Emerson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	April 2, 1929

20 UNDERTAKER Harry V. Wittle, 5314 Lombard ADDRESS

Spec.—2-29-28—L. F. S.—500 Blks.

16-31 E. North Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44621
1—PLACE OF DEATH

CERTIFICATE OF DEATH

90

REGISTERED NO. **E 44621**

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1536 Hoe St ST. 918 WARD)

2—FULL NAME Edwin E. Huth

(a) RESIDENCE NO. 1536 Hoe St ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie

6 DATE OF BIRTH (month, day, and year) Feb. 3, 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Piano Repairer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

10 NAME OF FATHER William Huth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Lorenz Tyler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mrs Minnie Huth
(Address) 1536 Hoe St

15 Filed ..... 19 ..... HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 11 1929 to Mch 31 1929 that I last saw him alive on Mch 30 1929 and that death occurred, on the date stated above, at 6-30 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 2 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Edema Lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) E. Gill Hall, M. D.

Mch 31, 1929 (Address) 1631 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cem	April 3 1929
20 UNDERTAKER	ADDRESS
Wm Cook	1211 Sc Paca

Spec.—2-29-28—L. F. S.—500 Bks.

Dr Strauss

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 44622

REGISTERED NO. E 44622

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 262 Norington Blvd ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William F. Stubb 3-25-72

(a) RESIDENCE NO. 262 Norington Blvd ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emma F. Stubb

6 DATE OF BIRTH (month, day, and year): June 6. 1860

7 AGE: Years 68 | Months 9 | Days 24 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Physician

(b) General nature of industry, business, or establishment in which employed (or employer): Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

10 NAME OF FATHER: Wm. A. Stubb Sr

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Ellen Watkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Emma F. Stubb

(Address) 262 Norington Blvd

15 Filed 3-2-1929 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 30. 1929

17 I HEREBY CERTIFY, That I attended deceased from 4/23/28, 19, to March 30, 1929, that I last saw h alive on March 30, 1929 and that death occurred, on the date stated above, at 2P m.

The CAUSE OF DEATH* was as follows:

Chr. Valvular Heart Disease

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm A Strauss, M. D.

3/30, 1929 (Address) 1901 Guilford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet

DATE OF BURIAL: 4-2 19 29

20 UNDERTAKER: Wm Cook

ADDRESS: 2112 Madison Ave

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44623 143-09 **E 44623**

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Franklin Square Hospital St. (or Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frida E. Mooney

(a) RESIDENCE NO. 4212 Liberty Heights St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. 2 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: John Mooney

6 DATE OF BIRTH (month, day, and year): June 27-1911

7 AGE — Years: 18 Months: 2 Days: 3 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Balto

(State or country) Md

10 NAME OF FATHER: Emil Crouse

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Balto Md

12 MAIDEN NAME OF MOTHER: Frida Agatha

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Germany

PARENTS

14 Informant: Emil Crouse

(Address) 5258 Nelson ave

Filed 1929 HAMPSON JONES, M. D. Registrar

APR 2 - 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Septic Infection from abortion, self induced as per statement

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) Chas. H. Brooke M. D.

(Coroner)

3/30, 1929 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Date of Burial 4-2-29 19

20 UNDERTAKER: [illegible] ADDRESS 1217 E. Fort

very important. See instructions on back of certificate. CAUSE, DURATION OF OCCUPATION 19

Spec.—1-19-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44624

CERTIFICATE OF DEATH.

100-801

E 44624

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2829 Hudson St (St.) 1-1 (WARD)

2-FULL NAME Bedrich Hanzlik

(a) RESIDENCE NO. 2829 Hudson St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Frances Hanzlik

6 DATE OF BIRTH (month, day, and year) Sept. 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	48	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hand Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Czechoslovakia

PARENTS

10 NAME OF FATHER Adam Hanzlik

11 BIRTHPLACE OF FATHER (city or town) (State or country) Czechoslovakia

12 MAIDEN NAME OF MOTHER Lukasova

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Czechoslovakia

14 Informant Frances Hanzlik

(Address) 2829 Hudson St.

15 Filed ..... 19 ..... C. HARRISON JONES, M. D.

Per ..... Registrar

2-1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 21, 1929, to March 31, 1929, that I last saw him alive on March 31, 1929, and that death occurred, on the date stated above, at 1.9 m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 11 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Joseph Pokorny, M. D.

4/1, 1929 (Address) 2200 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn — DATE OF BURIAL 4/2 1929

20 UNDERTAKER J. G. Connelly — ADDRESS Essex

TION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

Macer

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44625

CERTIFICATE OF DEATH.

101-001

E 44625
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 507 Mosher St. 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sylvia Macer

(a) RESIDENCE NO. 507 Mosher St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 5/23/1927

7 AGE — Years: 1 — Months: 10 — Days: 7 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of Industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town):
(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Ervin D. Macer

11 BIRTHPLACE OF FATHER (city or town):
(State or country) Md.

12 MAIDEN NAME OF MOTHER Brooks

13 BIRTHPLACE OF MOTHER (city or town):
(State or country) Balto. Md

14 Informant Elsie Macer
(Address) 507 Mosher St.

15 Filed ..... 19..... C. HAMPSON JONES, M. D., Registrar
By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19
3/30/1929

17 I HEREBY CERTIFY, That I attended deceased from Mar 7, 1929 to Mar 31, 1929, that I last saw h. alive on Mar 31, 1929, and that death occurred, on the date stated above, at 12.15 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia
(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia
(duration) yrs. mos. 5 ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) John H. Hampstone, M. D.

4/11, 19 29 (Address) 1012 N. Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial
Mt. Calvary Apr. 2 1929

20 UNDERTAKER ADDRESS
Wm. P. C. Elliott 1725 Ashland Ave

R 2-1929

very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44626

CERTIFICATE OF DEATH

24-001

E 44626

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 523 S. Dallas St. ST. 34 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Bartomai Dereniewicz

(a) RESIDENCE NO. 523 S. Dallas St. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Un 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Jacob Dereniewicz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Un.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Anna Dereniewicz

(Address) 523 S Dallas St

15 Filed 2 1929 HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31. 29

17 I HEREBY CERTIFY, That I attended deceased from March 25, 1929, to March 31 1929 that I last saw h[illegible] alive on March 31 1929 and that death occurred, on the date stated above, at 2 P M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Cardiac Dropsy

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What lest confirmed diagnosis?

(Signed) William L. Ryan M. D.

(Address) 501 N Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	April 3, 1929
20 UNDERTAKER	ADDRESS
F X Ozarenski	1730 East Av

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44627 E 44627

CERTIFICATE OF DEATH.

45

1-PLACE OF DEATH West Baltimore General REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Katie Miller

(a) RESIDENCE NO. 1519 Winchester ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 12, 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Mr. Dave Barth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Mrs. Rachael Levenson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Lewis

(Address) 1439 E. Baltimore

15 Filed 2-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1, 1929.

17 I HEREBY CERTIFY, That I attended deceased from Feb. 7, 1929, to April 1, 1929, that I last saw h alive on April 1, 1929 and that death occurred, on the date stated above, at 11:30 a. m.

The CAUSE OF DEATH* was as follows:

Generalized Carcinomatosis of Intestines and Pelvis

Biopsy-

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Secondary Metastasis - Lungs

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Feb. 18, 1929

Was there an autopsy?

What test confirmed diagnosis? Clinical and Biopsy

(Signed) Dan. Sullivan, M. D.

4/1, 1929 (Address) West Balto. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Lebanon Cemetery

DATE OF BURIAL 4-2-1929

20 UNDERTAKER Jos. Lewis

ADDRESS 1439 E. Baltimore

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44628

CERTIFICATE OF DEATH.

E 44628

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hospital (St.) 25-32 (Ward) 100-001

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Fisher

(a) RESIDENCE NO. ~~144~~ 2135 Annapolis Road, Westport ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: /

6 DATE OF BIRTH (month, day, and year): July 13-1925

7 AGE — Years: 8 — Months: — Days: 19 — If LESS than 1 day, hrs. or min.: /

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ~~Child~~

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Abe Fisher

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Gertrude Goldin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: J. Lewis (Address): 1132 E Balto

15 Filed 2 1929 H. HAMPSON JONES, M. D. Registrar

By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-1 1929

17 I HEREBY CERTIFY, That I attended deceased from 3-28 1929 to 4-1 1929, that I last saw her alive on April 1 1929, and that death occurred, on the date stated above, at 2:45 P m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia right
Hypostatic Congestion

..... (duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary)

..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Pathologist

(Signed) Frederick J. Wolf, M. D.

4-1, 1929 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cornduke — DATE OF BURIAL: 4-2-29

20 UNDERTAKER: Jack Lewis — ADDRESS: 1132 E Balto

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44629

CERTIFICATE OF DEATH

101-001

E 44629

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1230 McElderry St. 5-8 Ward)

2-FULL NAME Helen Walker

(a) RESIDENCE NO. 1230 McElderry St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

important. See instructions on back of certificate. Entire statement of OCCUPATION is very

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Black	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Walker

6 DATE OF BIRTH (month, day, and year) 1889

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	40			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer) 0
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) "
(State or country)

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) "
(State or country)

14 Informant Alexander Robinson
(Address) 705 S. Sharp St

Filed 4-2 1929 19 C. HAMPSON JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 31/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) inquiry find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Lobar Pneumonia

(duration) yrs. about 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Autopsy

(Signed) J. S. McBride, M. D.

4/2/29 (Address) 508 E. Monument Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Calvary Cem	4/2 1929
20 UNDERTAKER Byron Wright	ADDRESS 1218 McElderry

Spec.—2-29-28—L. F. S.—500 Bks.

E 44630

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001

E 44630

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 22-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Marian Little

(a) RESIDENCE NO. 649 W. Barre St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F	B	Sngl

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 3-1928

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		8 mo	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Car

12 MAIDEN NAME OF MOTHER Martha M. Lennan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Car.

Informant

(Address) JOHNS HOPKINS HOSPITAL

Filed APR 2 - 1929 G. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31-1929

17

I HEREBY CERTIFY, That I attended deceased from March 28, 1929, to March 31, 1929, that I last saw h[illegible] alive on March 31, 1929 and that death occurred, on the date stated above, at 12 Midnight p. m.

The CAUSE OF DEATH* was as follows:

Streptococcus Meningitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Acute otitis, media. Purulent bronchopneumonia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Spinal fluid culture

(Signed) T. C. Gardner, M. D.

3/31/1929 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 4-2 1929

20 UNDERTAKER [illegible]

ADDRESS 914 Eutaw

Spec.—2-29-28—L. F. S.—500 Bks.

E 44631

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 44631

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS [redacted] REGISTERED NO. 101-001

CITY OF BALTIMORE: (No. [redacted] ST., 3-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Richard Curtis

(a) RESIDENCE NO. 236 S. Bethel ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillian Curtis

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Curtis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Emma Ross

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Records of BALTIMORE CITY HOSPITALS (Address)

Filed APR 2 - 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 26, 1929, to March 29, 1929, that I last saw him alive on March 29, 1929 and that death occurred, on the date stated above, at 5:40 A m.

THE CAUSE OF DEATH* was as follows:

Lobar Pneumonia
Bilateral

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-Ray

(Signed) John E. Moran, M. D.

, 19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	4-2 1929
UNDERTAKER David Easton	ADDRESS 916 Ca

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44632 E 44632

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1518 Harlem Ave WARD) 16-22

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James J Cain

(a) RESIDENCE NO. 1518 Harlem Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clara Cain

6 DATE OF BIRTH (month, day, and year) March 12, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70		18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Butcher

(b) General nature of industry, business, or establishment in which employed (or employer) — 113

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Portsmouth Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Clara Cain

(Address) 1518 Harlem Ave

15 Filed 4-2-1929 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30 1929

17 I HEREBY CERTIFY, That I attended deceased from March 27, 1929, to March 30, 1929, that I last saw him alive on March 30, 1929, and that death occurred, on the date stated above, at 6.50 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Mitral Heart Disease

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. A. O'Neill M. D.

4/1, 1929 (Address) 108 N Sutton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL 4/2 1929

20 UNDERTAKER Wm Cook — ADDRESS 1219 St Paul St

Print clearly—important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44633

CERTIFICATE OF DEATH

90 E 44633

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 750 W. Hamburg 4-1-29 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julius R Einhardt

(a) RESIDENCE NO. 750 W. Hamburg St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Late Nannie E.

6 DATE OF BIRTH (month, day, and year): Dec 2 1857

7 AGE: Years 71 Months 9 Days 29 IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Musician

(b) General nature of industry, business, or establishment in which employed (or employrr)

(c) Name of employer

9 BIRTHPLACE (city or town): Germany

(State or country)

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14 Informant: Carry Schaefer

(Address): 750 W. Hamburg st

15 Filed APR 2 - 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr. 1 19 29.

17 I HEREBY CERTIFY, That I attended deceased from June 1 19 28 to Apr. 1 19 29.

that I last saw him alive on March 31 19 29.

and that death occurred, on the date stated above, at 3 30 am.

The CAUSE OF DEATH* was as follows:

Myocarditis

Mitral Regurgitation

Interval: mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

de Compensation

(Duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? No.

What (test confirmed diagnosis)? Clinical

(Signed) W. B. Freiberger M. D.

4/1 19 29 (Address) 682 Montgomery Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: National Cemetery — Date of Burial 4/2 19 29

20 UNDERTAKER: D. J. Donovan & Bro — ADDRESS 1127 E Baltimore

very important. See instructions on back of certificates.

...ing, ...ness. Last statement of OCCUPATION is

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44634 — **CERTIFICATE OF DEATH** — 31 — **E 44634**

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No.) Baltimore City Hospitals ST., (T. B.) 5 9 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lucille Robinson

(a) RESIDENCE NO. 1424 E. Fayette st. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1906

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
23	22			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Factory work

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Bruce Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records

(Address)

Filed APR 2 1929 19 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30, 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan. 11, 1929 to March 30, 1929,

that I last saw her alive on March 30, 1929

and that death occurred, on the date stated above, at 8.45 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical and autopsy

(Signed) Hugh Smith, M. D.

3-31, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lancaster Co. Va — DATE OF BURIAL April 2 1929

20 UNDERTAKER Edward Bryan — ADDRESS 1631 orleans st

Cor.—12-9-25—A Co.—200 Bks.

44635

HEALTH DEPARTMENT—CITY OF BALTIMORE

X 31 E 44635

CERTIFICATE OF DEATH.

1-PLACE OF DEATH S/S Levernbank, American Sugar Refining Co. Foot of Hoode St. 24-35 REGISTERED NO.

City of BALTIMORE: (No.) St. 22nd Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ingot Ollie.

(a) RESIDENCE NO. Ceylon, India. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Do not know.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	40	----------		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) S/S Levernbank.

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Ceylon, India.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Do not know.

14 Informant John Syme.

(Address) 1st. officer S/S Levernbank.

Filed 1929 HAMILTON JONES, M. D. Registrar

PR 2-1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage.
Pulmonary Tuberculosis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) M. D.
(Coroner)

4/1, 1929 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem Date of Burial Apr 2 1929

20 UNDERTAKER John O Mitchell Sons ADDRESS 1900 Eutaw Place

very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44636

CERTIFICATE OF DEATH.

90

E 44636

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 702 Gorsuch ave ST., 9-4th WARD)

2-FULL NAME Emma C. Hyatt

(a) RESIDENCE NO. 702 Gorsuch ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 88 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Governor Hyatt

6 DATE OF BIRTH (month, day, and year) Feb 25 41

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	88	1	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer self

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Stephen Todd

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Julia Ann Snodgrass

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md Baltimore

14 Informant James H Hyatt (Address) 702 Gorsuch Ave

15 Filed R 2- 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 31 1929

17 I HEREBY CERTIFY, That I attended deceased from Apr 19, 1918, to Mar 31, 1929, that I last saw h alive on Mar 31, 1929, and that death occurred, on the date stated above, at 1.15 P. m.

The CAUSE OF DEATH* was as follows:

Rectal abscess + Endocarditis (valvular insufficiency)

(duration) 11 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? usual tests

(Signed) H. E. Knight, M. D.

3/31, 1929 (Address) 4025 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL Apr 2 1929

20 UNDERTAKER John O. Mitchell & Sons ADDRESS 1500 Eutaw Place

Spec.—2-29-28—L. F. S.—500 Bks.

E 44637

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

58-001

E 44637

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 701 E. 22nd ST., 9-W-6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Florence Streett

(a) RESIDENCE NO. 701 E. 22nd ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ~~Feb. 12 1867~~

6 DATE OF BIRTH (month, day, and year) Feb 12, 1867

7 AGE — Years: 62 | Months: 1 | Days: 20 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER John T. Streett

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER Mary M. Bay

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Levin T. Streett

(Address) 701 E. 22nd

Filed APR 2 - 1929

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1 - 1929

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1929, to April 1, 1929,

that I last saw h alive on April 1, 1929,

and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Arteriosclerosis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. E. Pleasants M. D.

, 19 (Address) 1734 Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	April 3 1929
UNDERTAKER Wm. J. Tuckner Sons	ADDRESS N. Y. Pa.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44638

CERTIFICATE OF DEATH.

100-001

E 44638

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3504 Benvenista Ave ST. 1357 WARD)

2-FULL NAME Charles Daniel Amor.

(a) RESIDENCE No. 3504 Benvenista Ave, ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth

6 DATE OF BIRTH (month, day, and year) Feb. 3d 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	65	1	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter 015

(b) General nature of industry, business, or establishment in which employed (or employer) Car Shops.

(c) Name of employer Penna RR Co Balto Md.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER John A. Amor.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Freeland Md.

12 MAIDEN NAME OF MOTHER Julia Rosemaker.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna.

14 Informant Effie Amor

(Address) 3504 Egerton Road

15 Filed 2-1929, 19 M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb 8, 1929, to March 31, 1929, that I last saw him alive on March 30, 1929 and that death occurred, on the date stated above, at 8.15 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. 1 mos 26 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] Jones, M. D.

4/2, 1929 (Address) 720 N. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cemetery, Freeland Md.	April 2nd 1929

20 UNDERTAKER Hartenstein Rosemaker ADDRESS Mt Airy Md

HANSON JONES M. D.

Spec.—1-12-23—M&T—500 Bks.

E 44639 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 161-001 E 44639

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital WARD)

2-FULL NAME Baby Girl Phelps

(a) RESIDENCE NO. Glenburney Md. ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 30-1929

7 AGE: Years | Months | Days: 1 | If LESS than 1 day: 21 hrs. or 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): University Hospital Baltimore - Md.

PARENTS

10 NAME OF FATHER: Nelson Stanley Phelps

11 BIRTHPLACE OF FATHER (city or town) (State or country): Glenburney - Md.

12 MAIDEN NAME OF MOTHER: Margaret Irene Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Harmona Md.

14 Informant: Nelson S. Phelps. (Address) Brooklyn Md

15 Filed R 2- 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 1 1929

17

I HEREBY CERTIFY, That I attended deceased from March 30, 1929, to April 1, 1929, that I last saw h- alive on April 1, 1929, and that death occurred, on the date stated above, at 8.[illegible] a.m.

The CAUSE OF DEATH* was as follows:

Prematurity (36 weeks)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Congenital Atelectasis

(duration) yrs. mos. 1 day 21 hrs 30

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Findings

(Signed) Jas. T. Hobbs M. D.

1929 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Friendship Cem — DATE OF BURIAL: Apr 2 1929

20 UNDERTAKER: W. E. Ericksen & Sons — ADDRESS: N. Y & Pa

Spec.—1-10-21—M&T—1500 Bks.

44640 HEALTH DEPARTMENT—CITY OF BALTIMORE E 44640

CERTIFICATE OF DEATH.

1-PLACE OF DEATH U. S Marine Hospital, Balt Md, REGISTERED NO.

CITY OF BALTIMORE: (No.) Balt Md (St.) 17-51 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Fisher

(a) RESIDENCE NO. Pocomoke City Md ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs 1 mos. 7 ds. How long in U. S., if of foreign birth? — yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 14 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	5	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) Seaman

(c) Name of employer S/S Gopher

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Geo. Fisher

11 BIRTHPLACE OF FATHER (city or town) (State or country) N-Y.

12 MAIDEN NAME OF MOTHER Sadie Hurley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Self (Address)

15 Filed PR 2 - 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 29 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb 14, 1929, to March 29, 1929, that I last saw h alive on March 29, 1929, and that death occurred, on the date stated above, at 5:25 P m.

The CAUSE OF DEATH* was as follows:

Erysipelas, left leg

(duration) yrs. mos 43 ds.

CONTRIBUTORY (Secondary) Pyemia and Septicaemia

(duration) yrs. mos. 16 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of 3-27-29 / 3-28-29

Was there an autopsy? no Pharmacy

What test confirmed diagnosis? Physical findings

(Signed) C. Schlichter, M. D.

3-29-1929 (Address) U S Marine Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mays (Hamp) DATE OF BURIAL Apr 2 1929

20 UNDERTAKER E LeRoy Stapleton ADDRESS 125 Main

Filed for Registration HAMILTON JONES, M. D.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44641

E 44641

CERTIFICATE OF DEATH.

66

1-PLACE OF DEATH

City of BALTIMORE: (No. Arlington Ave & Wayne St. 46th Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Susie Stillings

(a) RESIDENCE NO. 226 Bowers Court St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of William H Stilling

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of indnstry, business, or establishment in which employed (or employer) Of

(c) Name of employer

9 BIRTHPLACE (city or town) Crisfield

(State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Mrs Katie Williams

(Address) 226 Bowers Court

15 Filed 4-2-1929 C. HAMPSON JONES, M. D. Registrar Per _____

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/29 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) _____

(duration) ____ yrs. ____ mos. ____ ds.

(Signed) Chas H Brooke M. D.

(Coroner) City Coroner

4/1, 1929 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Mt. Auburn Cemetery	April 2, 1929
20 UNDERTAKER Mrs. Katie R. Williams	ADDRESS 322 N Schroeder St

Very Important. See instructions on back of certificate.

Spec.--2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44642

CERTIFICATE OF DEATH

× 44

E 44642

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 19 W. 27th St. ST. 12-51 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Clayton

(a) RESIDENCE NO. 19 W. 27th St. ST., WARD 9a

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 13. 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	7	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stationary Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Chas C. Clayton

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Mary Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Granddaughter (Address) 19 W 27th St Balto Md

15 Filed 2-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31/29

17 I HEREBY CERTIFY, That I attended deceased from March 23, 1929, to March 31, 1929, that I last saw him alive on March 31, 1929, and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) Months ds.

CONTRIBUTORY (Secondary) Hemiplegia

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? X-Ray

(Signed) C. Hampson Jones, M. D.

, 19 (Address) 739 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cem	Apl 2 1929
20 UNDERTAKER	ADDRESS
H Hynes	1324 Eutaw St

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44643

CERTIFICATE OF DEATH.

44 E 44643

1-PLACE OF DEATH Sinai Hosp.

REGISTERED NO.

CITY OF BALTIMORE: (No. 1420 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mollie Herling

(a) RESIDENCE NO. 1940 Linden av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Morris Herling

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE: Years 72; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): M. Herling 1940 Linden ave.

15 Filed 4-2-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-1 1929

17 I HEREBY CERTIFY, That I attended deceased from 4-1, 1929, to 4-1, 1929.

that I last saw her alive on 4-1, 1929

and that death occurred, on the date stated above, at 9. P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Failure c pulm. Edema
Cere. & Cardiac and Stomach
Diabetes Mellitus c Pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Bayard Clark, M. D.

, 19 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pikesville

DATE OF BURIAL: 4-2-19

20 UNDERTAKER: Jack Levin

ADDRESS: 1439 Eutaw

Cor.—10-10-29—A Co.—100 Bks.

E 44644

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 44644

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St. 4-30 Ward)

2-FULL NAME William Conley

(a) RESIDENCE NO. 1804 - 7th St. N.W. Washington Ward D.C.
(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. / ... ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Negro	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Roberta Conley

6 DATE OF BIRTH (month, day, and year) unk

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	28			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Chauffeur
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) N. Y. City

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Unknown

14 Informant Roberta Conley
(Address) 1804 7th St. N.W.

15 Filed ..... 19.. HAMPSON JONES, M. D.
Registrar

APR 2 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Fractured Skull
Automobile Accident

..... (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Washington Blvd
Did an operation precede death? ... Date of ...
Was there an autopsy? ...
What test confirmed diagnosis? ...
(Signed) Eugene Zeller, M. D.
April 1 1929 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington D.C. DATE OF BURIAL 4/2 1929

20 UNDERTAKER Edward Wendler & Bro ADDRESS 5[illegible]

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 44645

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44645

CERTIFICATE OF DEATH

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS [redacted] REGISTERED NO. 49

CITY OF BALTIMORE: (No. [redacted] ST., 1724 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Maggie Denby

(a) RESIDENCE NO. 6 N. Bradley Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced (or) WIFE of Harley Denby

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Bence Chase

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant BALTIMORE CITY HOSPITALS (Address)

15 Filed APR 2 - 1929 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-30-29

17 I HEREBY CERTIFY, That I attended deceased from 3-28, 1929, to 3-30, 1929, that I last saw her alive on 3-30, 1929, and that death occurred, on the date stated above, at 2.00 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma Pancreas

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Secondary Anemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Lab. Path. & Clinical

(Signed) John E. Moran, M. D.

19 (Address) BALTIMORE CITY HOSPITALS [redacted]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holehouse Cem

UNDERTAKER Samuel Hensley

DATE OF BURIAL 4/2 1929

ADDRESS 1 Bridge

Cor.—10-10-29—A Co.—100 Bks.

E 44646

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

89 E 44646

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 919 Boyd St. 18-29 Ward)

2-FULL NAME Louis Gross

(a) RESIDENCE NO. 919 Boyd St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

Important. See instructions on back of certificate. Entire statement of OCCUPATION is very

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Celia Gross

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	35		-	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER Charles Gross

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Celia Lively

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant
(Address) 919 Boyd St

15 Filed 2-1929 19 C. HAMILTON JONES, M. D. Registrar
Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 27 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zellers M. D.

3/31. 1929. (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL April 2nd 19 29

20 UNDERTAKER A. Jones — ADDRESS 111 S. Gilmor

Spec.—1-10-21—M&T—1500 Bks.

E 44647 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 44647

REGISTERED NO.

1-PLACE OF DEATH United States Marine Hospital,

CITY OF BALTIMORE: (No.) Baltimore, Maryland. ST., 1-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Brodka

(a) RESIDENCE No. 3121 Foster Ave., Balto., Md. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 34 yrs 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 1 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Oiler

(b) General nature of industry, business, or establishment in which employed (or employer) Seaman

(c) Name of employer SS Winona County

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland

PARENTS

10 NAME OF FATHER Frank Brodka

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Catherine ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Records U.S. Marine Hospital, (Address) Baltimore, Maryland.

15 Filed APR 2 - 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb. 12 1929 to April 1 1929 that I last saw him alive on March 31 1929 and that death occurred, on the date stated above, at 5:40 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis, pulmonary

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? clinical & laboratory

(Signed) Ralph E Foster, M. D.

(Address) U.S. Marine Hospital, Balto. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Rotary Cemetery	April 4 1929
20 UNDERTAKER Lilly & Gilbert	ADDRESS 404 N Howard St

Keep flat

See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

Pryor

HEALTH DEPARTMENT—CITY OF BALTIMORE

44648

CERTIFICATE OF DEATH

+/ 167-001

E 44648

REGISTERED NO.

1-PLACE OF DEATH

City of Baltimore: (No. 1226 N. Calvert St., 11-15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Melvin A. Pryor

(a) RESIDENCE NO. 1226 N. Calvert St., Ward Hagerstown Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
67	about		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work — no
(b) General naturo of industry, business, or establishment in which employed (or employer) no
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Geo. W. Pryor

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Sarah ~~A~~ Bahrman

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant M. A. Pryor
(Address) Thurmont Md

15 Filed ..... 19.. C. HAMPSON JONES, M. D.
Registrar

APR 2 - 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest) (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Jury (Jury, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Suicide by Illuminating gas

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? 4

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? —

(Signed) H. T. Riley Byrne, M. D.

Apr. 29 19 9 (Address) 1632 Brooklyn

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Thurmont Md — DATE OF BURIAL Apr 5 1929

20 UNDERTAKER M. L. Creager Son — ADDRESS Thurmont Md

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44649 **CERTIFICATE OF DEATH** 43 **E 44649**

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. 21-31 ST. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alexander Boyer

(a) RESIDENCE NO. 1107 Russell ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Cons't mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col.	Widower

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Lena Boyer

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER John ? Boyer

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Thomas

13 BIRTHPLACE OF MOTHER (city or town) Chestertown (State or country) Md

14 Informant Hospital Records (Address)

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

R 2-1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-31-29

17 I HEREBY CERTIFY, That I attended deceased from 1-8, 1929, to 3-31, 1929, that I last saw h(IM) alive on 3-31, 1929, and that death occurred, on the date stated above, at 3:15 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Floor of Mouth

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jolan E. Moran, M. D.

19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	April 4, 1929
20 UNDERTAKER Mrs. Katie R. Williams	ADDRESS 322 N. Gilmor St.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44650

CERTIFICATE OF DEATH

BALTIMORE CITY HOSPITALS

E 44650

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. [redacted] ST. 22-31 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph Spriddle

(a) RESIDENCE NO. 207 W. Hill ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Mart Spriddle

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Lizzie Tyson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Records of BALTIMORE CITY HOSPITALS

Filed [illegible] 19 [illegible] Registrar

R 2- 1929 H. [illegible] JONES M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 30, 1929

17

I HEREBY CERTIFY, That I attended deceased from February 1, 19 29 to March 30, 19 29

that I last saw him alive on March 30, 19 29

and that death occurred, on the date stated above, at 8:30 m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) John E. Moran, M. D.

, 19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
W. Arlington et	April 3 1929
20 UNDERTAKER	ADDRESS
J. E. Brown & Son	1020 Madison

Spec.—2-29-28—L. F. S.—500 Bks.

E 44651 HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

CERTIFICATE OF DEATH

E 44651

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

CITY OF BALTIMORE: (No. ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Amelia Green or Paine

(a) RESIDENCE NO. 535 W. Biddle ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ernest

6 DATE OF BIRTH (month, day, and year) Unk

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
58				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) 041

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md

PARENTS

10 NAME OF FATHER Stephen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER LeVinia

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Richard
(Address) BALTIMORE CITY HOSPITALS

15 Filed 2-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-29-29

17 I HEREBY CERTIFY, That I attended deceased from 3-26, 1929, to 3-29, 1929, that I last saw h[illegible] alive on 3-29, 1929, and that death occurred, on the date stated above, at 6:15 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia, left

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic myocarditis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) John E. Moran, M. D.

. 19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Ct	April 3 1929
20 UNDERTAKER	ADDRESS
C. H. Brown & Son	1821 Mondy

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44652

CERTIFICATE OF DEATH.

E 44652

REGISTERED NO._____

1-PLACE OF DEATH Inwood Harbor 1826

City of BALTIMORE: (No. 4041 President St., 3-5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Unknown

(a) RESIDENCE NO. Unknown St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE: Years: about 30 Months: Days: IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: 047

(b) General nature of industry, business, or establishment in which employed (or employer): ?

(c) Name of employer

9 BIRTHPLACE (city or town): ?

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town): ?

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town): ?

(State or country)

14 Informant

(Address)

15 Filed APR 2 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 29 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Accidental Drowning

Sudden (duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

.....(duration) .....yrs. .....mos. .....ds.

(Signed) James M Hamilton M. D.

(Coroner)

3.22, 1929 (Address) 7000 Harford

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: PUBLIC CEMETERY. Date of Burial, 19

20 UNDERTAKER: John M. Bischoff ADDRESS: Commissioner Health

APR 2 1929

APR 2 - 1929

Very Important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44653

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

+90

E 44653

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of BALTIMORE: (No. Washington Boulevard 21-24 Ward)
about 5 miles from Baltimore

2-FULL NAME Albert J. Sperbeck

(a) RESIDENCE NO. Summit N.J. St. _____ Ward _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred _____ yrs. _____ mos. 1 ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida M. Sperbeck

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	68	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Machinist
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer —

9 BIRTHPLACE (city or town) .....
(State or country) N. Y.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Unknown

14 Informant Howard C. Sperbeck
(Address) Summit N.J.

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D., Registrar

APR 2 - 1929 THE MORGUE

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3/27 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Died Suddenly ..... Was out of Auto. Ate Lunch

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. F. Moore M. D.
(Coroner)

3/27, 1929 (Address) Brooklyn Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY. Date of Burial APR 2 - 1929

20 UNDERTAKER Commissioner Health. ADDRESS

very important. See instructions on back of certificate.

Spec.—3-29-28—L. F. S.—500 Blks. Bertha Horcher

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44654 CERTIFICATE OF DEATH 129 E 44654

1—PLACE OF DEATH REGISTERED NO.

CITY OF BALTIMORE: (No. 644 S. Curley St ST., 12 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Bertha Horcher

(a) RESIDENCE NO. 644 S. Curley Street ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Nov. 1-1880

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
48	4	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Ignatius Rybarczyk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Antonisia Guligoska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Joseph Horcher - Son

(Address) 644 S. Curley Street

Filed APR 2- 1929 19 W. P. [illegible] REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30 29

17 I HEREBY CERTIFY, That I attended deceased from Mar. 1, 1929, to Mar 30, 1929.

that I last saw h[illegible] alive on Mar. 30, 1929

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Chronic Myocarditis

Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension

Uremia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) G. Joseph Tinker, M. D.

, 19 (Address) 1050 Edgewood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	April 3 19 29

20 UNDERTAKER George A. Weber ADDRESS 705 Lamm st.

Spec.—2-29-28—L. F. S.—500 Bks.

E 44655

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 44655

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 427 S. Madeira Street ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jacub Fisher/Or-Wisniewski

(a) RESIDENCE NO. 427 S. Madeira Street ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May, 10-1890

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38	10	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Joseph Wisniewski

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER Lena Tomicka

13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)

14 Informant Mary L. Hitchens Sister

(Address) 427 S. Madeira Street

15 Filed ... 1929 ... HARRISON JONES, M. D. Registrar

TR2 - 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31/1929

17 I HEREBY CERTIFY, That I attended deceased from March 17, 1929 to March 31, 1929

that I last saw h... alive on March 31, 1929

and that death occurred, on the date stated above, at 2:10 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Andrew Kuncewicz, M. D.

April, 1929 (Address) 2579 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem.	April 3 1929.
20. UNDERTAKER	ADDRESS
George A. Weber	735 S. Ann St.

Cor.—12-9-25—A Co.—200 Bks.

E 44656

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 44656

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Franklin Square Hospital Ward)

2-FULL NAME Philipp Goldberg

(a) RESIDENCE NO. 21 Lloyd St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1882

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
47				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Russia

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Brother

(Address)

Filed 4-2, 1929 C. HAMPSON JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Chas. A. Bowie M. D.
(Coroner)

4/2 1929 (Address) Brooklyn Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.,.....ds. In the State.....yrs.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem. Date of Burial 4-2-1929

20 UNDERTAKER Jack Levin ADDRESS 1439 E Balto

Very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 44657

HEALTH DEPARTMENT—CITY OF BALTIMORE

90

E 44657

CERTIFICATE OF DEATH

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS [redacted] REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 18-N WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James N. Phelps

(a) RESIDENCE NO. 844 W. Fayette ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None Peddler

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Austin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ellen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland Md

14 Informant [redacted] (Address) BALTIMORE CITY HOSPITALS

15 Filed 2-[redacted]-1929 W. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3-26-29

17 I HEREBY CERTIFY, That I attended deceased from 8-6, 1928, to 3-26, 1929, that I last saw h[illegible] alive on 3-26, 1929, and that death occurred, on the date stated above, at 1:30 A m.

The CAUSE OF DEATH* was as follows:

Chr. myocarditis

1

CONTRIBUTORY (Secondary) Birth Paralysis + Spastic (duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) R. M. Block, M. D.

, 19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or if Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL APR 2-, 1929

UNDERTAKER [redacted]

ADDRESS

Commissioner Health.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44658

101-001

E 44658

CERTIFICATE OF DEATH

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS [redacted] 4-16

REGISTERED NO.

CITY OF BALTIMORE: (No. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frances Nelson

(a) RESIDENCE NO. 1314 W. Saratoga ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Jacob Owings

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Eliza Emerson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Records of
(Address) BALTIMORE CITY HOSPITALS

15 [redacted] 1929, C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 28, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 27, 1929 to March 28, 1929;

that I last saw her alive on March 28, 1929

and that death occurred, on the date stated above, at 6:35 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia, left

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam.

(Signed) John E. Osborn, M. D.

(Address) BALTIMORE CITY HOSPITALS [redacted]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

UNIVERSITY OF MARYLAND

Commissioner of Health

APR 2 19

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44659

CERTIFICATE OF DEATH.

31 E 44659

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore Hosp St. 4-16 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Grace Reid

(a) RESIDENCE NO. 771 W Saratoga St. _____ Ward _____

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	21			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant

(Address)

15 Filed _____ 19___ C. HAMPSON JONES, M. D.

3238 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 21 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) about 6 mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) James W. Young M. D.
(Coroner)

3/29 1929 (Address) 700 E Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? 771 W Saratoga St

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial 19

20 UNDERTAKER ADDRESS

Commissioner of Health APR 2 - 1929

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 44660

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44660

CERTIFICATE OF DEATH.

66

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 641 W. Lexington St. 25 Ward)

2-FULL NAME Thomas Hill

(a) RESIDENCE NO. 641 W. Lexington St. ____ Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Hill

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Thomas Hill

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Mary Hill

(Address) 641 W Lexington St

15 1929 C. HAMPSON JONES, M. D.

THE MORGUE. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 27 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism.

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary)

(duration) ___ yrs. ___ mos. ___ ds.

(Signed) Eugene Feltes M. D.

(Coroner)

4/1, 1929 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ___ yrs. ___ mos. ___ ds. In the State ___ yrs. ___ mos. ___ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

UNIVERSITY OF MARYLAND APR 2 - 1929

20 UNDERTAKER Commissioner Health

ADDRESS

very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 44661

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 44661

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 521 Mt. Holly St. 20-71 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Patrick Flanagan

(a) RESIDENCE NO. 521 Mt. Holly ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary E. Flanagan

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About	70	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer): B. & O. R.R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Thomas Flanagan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Bridget McLaughlin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs Louis H. Van Hollen

(Address) 521 Mt Holly St

15 Filed 2-1929 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 31-1929

17 I HEREBY CERTIFY, That I attended deceased from Jan., 19 27, to March 30, 19 29, that I last saw h alive on March 31, 19 29, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Cerebral arterio Sclerosis

(duration) At least 2 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary): Myocardial Degeneration

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Standish McClung, M. D.

, 19 (Address) 1609 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: 4/3 1929

20 UNDERTAKER: Chas S. Evans & Son

ADDRESS: 1130 N. Mt Royal Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

E 44662

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44662

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2437 E Preston St., 8 91 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Fanny Hubbard

(a) Residence No. 2437 E Preston St., 8 Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Feb 27 1837

7-AGE, 92 yrs. 1 mos. 4 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... none

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Capt. J Hubbard.

11-BIRTHPLACE OF FATHER (city or town)..... (State or Country), Cambridge Md.

12-MAIDEN NAME OF MOTHER, — Trego

13-BIRTHPLACE OF MOTHER (city or town)..... (State or Country), Balto Md

14-

(Informant)..... R. G. Boudyn

(Address)..... 3205 Mondawmin Ave

15-

Filed 1929

C. HAMPSON JONES, M. D.
Registrar.

Per .....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 1 1929

17- I HEREBY CERTIFY, That I attended deceased from March 23 1929 to April 1 1929

that I last saw h[illegible] alive on March 30 1929

and that death occurred, on the date stated above, at 8.20 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorhage

(Duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Arteria sclerosis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis?.....

(Signed) D. L. Dergon M. D.

4/1/29, 19 (Address) 1305 N Patterson Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ Baltimore Cemetery DATE OF BURIAL, April 3, 1929

20-UNDERTAKER Wm. J. Tickner & Son ADDRESS North & Pa

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44663 90 E 44663

CERTIFICATE OF DEATH

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS [redacted] REGISTERED NO. 16-27

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James McDougal

(a) RESIDENCE NO. None ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Canada
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Canada
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Canada

14 Informant Records of
(Address) BALTIMORE CITY HOSPITALS

15 Filed 2-1929 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30, 1929

17 I HEREBY CERTIFY, That I attended deceased from December 29, 1928 to March 30, 1929

that I last saw him alive on March 30, 1929

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Coronary Occlusion (1 day)
Chronic Myocarditis

..... (duration) 4 yrs. ..... mos. ..... da.

CONTRIBUTORY (Secondary) Arteriosclerosis

..... (duration) 4 yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) John E. Moran, M. D.

, 19 (Address) BALTIMORE CITY HOSPITALS [redacted]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart	4-2 1929
UNDERTAKER J. J. Fahey & Sons	ADDRESS 1318 Light

Spec.—1-12-23—M&T—500 Bks.

E 44664 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 44664

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 607 W Lombard St. 3-4 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Matilda Renninger.

(a) RESIDENCE No. 607 W Lombard ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE: Years 70 | Months | Days | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Peter Renninger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Matilda Koppler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Geamany

14 Informant: George Renninger (Address) 607 W Lombard

15 Filed 2 Apr 1929, 19.. C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1st 1929

17

I HEREBY CERTIFY, That I attended deceased from December 1st, 1928, to April 1st, 1929, that I last saw her alive on March 31st, 1929, and that death occurred, on the date stated above, at 11:30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) ME yrs. — mos — ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis.

(duration) — yrs. 4 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Nonmany.

(Signed) Stephen F. Steelman, M. D.

, 19 (Address) 6 East Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Apr 4 1929

20 UNDERTAKER: George J Smith — ADDRESS 1532 Hollins

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44665

CERTIFICATE OF DEATH

90 **E 44665**

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 521 Denison ST. 20-10 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charlotte Ellen Hogg

(a) RESIDENCE NO. 521 Dennison ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widnwed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 3, 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	89		29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John W. Hogg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Martha A. Chambers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Worthington Hogg

(Address) 521 Dennison St.

15 Filed 2-1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 1, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 15, 1927, to Apr 1, 1929, that I last saw her alive on Mar 31, 1929 and that death occurred, on the date stated above, at 1.15 a m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) General debility

(duration) 8 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operatinn precede death? No Date of

Was there an autopsy? No

What test confirmed diagnnsis? Clinical

(Signed) H. Clyde Mansel, M. D.

, 19 (Address) Eat Court Apts.

*State the Disease Causing Death, or in deaths frnm Vinlent Causes, state (1) Means and Nature of Injury, and (2) whether Aecidental, Suicidal, or Homicidal. (See reverse side for additinnal spaee.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	Apr 3 1929
20 UNDERTAKER George J. Smith	ADDRESS 153 L Hollins

Spec.—2-29-28—L. F. S.—500 Bks.

E 44666

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44666

CERTIFICATE OF DEATH

90

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3009 Eastern Ave. ST. 1-2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Louis H. Reith

(a) RESIDENCE NO. 3009 Eastern Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 20, 1858.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71	1	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Superintendent

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Henry L. Walker

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Francis Reith

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Marg't. Weller

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mary M. Adams
(Address) 3009 Eastern ave.

15 Filed 2 1929 G. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2 1929

17 I HEREBY CERTIFY, That I attended deceased from March 30, 1929, to April 2, 1929, that I last saw h[illegible] alive on April 1, 1929 and that death occurred, on the date stated above, at 12 0 [illegible] m.

The CAUSE OF DEATH* was as follows:

Flatulent Dyspnea & Cardiac Insufficiency

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency & Indigestion (duration) [illegible] yrs. mos. ds.

18 Where was disease contracted if not at place of death? 3009 Eastern Av

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) W. S. Carman, M. D.

4-2, 1929 (Address) 1701 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem.	Apr. 4 1929
20 UNDERTAKER	ADDRESS
Wm. C. Black	921 N Broadway

Spec.—2-29-28—L. F. S.—500 Bks.

E 44667

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44667

CERTIFICATE OF DEATH

74001

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2319 E. Oliver ST. 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry C. Groh

(a) RESIDENCE NO. 2319 E. Oliver ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma M. Groh

6 DATE OF BIRTH (month, day, and year) Sept. 18, 1879,

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49	6	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Henry Groh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret E. Heineker

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Emma M. Groh
(Address) 2319 E. Oliver St.

15 Filed 2 1929 C. HAMPSON JONES, M. D. Registrar
By Oak

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31st 1929

17 I HEREBY CERTIFY, That I attended deceased from March 31, 1929, to March 31, 1929,

that I last saw h alive on March 31, 1929

and that death occurred, on the date stated above, at 12 15 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) L. L. Gordy, M. D.

4-1, 1929 (Address) 4218 Harford Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	Apr. 3 1929
20 UNDERTAKER	ADDRESS
Mrs. Albert E. Fuller	4806 Harford ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44668

CERTIFICATE OF DEATH

E 44668

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2541 Eastern St. 1-3 Ward)

2-FULL NAME Joseph Nowraski

(a) RESIDENCE NO. 2541 Eastern St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wanda Nowraski

6 DATE OF BIRTH (month, day, and year) Oct 16 - 1870

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	59	4	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Designer.
(b) General nature of industry, business, or establishment in which employed (or employer) at home.
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Poland

PARENTS

10 NAME OF FATHER unknown.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland.

14 Informant SON. Joseph Nowraski
(Address) 2541 Eastern ave

15 1929 19 I. AMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Nov 2 - 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH was as follows:

Coal Gas Poisoning - Ill.

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What confirmed diagnosis? Examination

(Signed) J. C. Eades, M. D.

2.29 (Address) 143 W Preston

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cem

DATE OF BURIAL Nov 5 1929

20 UNDERTAKER Edward L Lilly

ADDRESS 838 Glenmore Ave

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

Dr Bishop 601 Sheridan Ave

E 44669 HEALTH DEPARTMENT—CITY OF BALTIMORE **E 44669**

31

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3936 Frisby ST., 9-47 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Gerhardt Rahe

(a) RESIDENCE NO. 3936 Frisby ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Clara E. Rahe

6 DATE OF BIRTH (month, day, and year) June 9, 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	51	9	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Charles Rahe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Landrock

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Clara E. Rahe

(Address) 3936 Frisby St

15 Filed 3-1929, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30. 1929

17 I HEREBY CERTIFY, That I attended deceased from March 2, 1929, to March 30, 1929, that I last saw h[illegible] alive on March 29, 1929 and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculosis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Same

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) S. W. Bishop, M. D.

March 30, 1929 (Address) 601 Sheridan Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cemetery	March 31 19 29
20 UNDERTAKER J. Cohn	ADDRESS 2102 Pa Ave

Spec.—2-29-28—L. F. S.—500 Bks.

G. E. Biddle

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44670

CERTIFICATE OF DEATH

24-001

E 44670

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1574 W. Pratt ST., 8 WARD)

2—FULL NAME Henrietta F. Reed

(a) RESIDENCE NO. 1574 W. Pratt St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: John H.

6 DATE OF BIRTH (month, day, and year): Jan 7 66

7 AGE: Years 63 | Months 2 | Days 2 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

10 NAME OF FATHER: Christian F. Seefeld

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Matilda F. Seefeld

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Edward Seefeld

(Address) 1574 W. Pratt St.

15 Filed MAR 3-1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 1929

17 I HEREBY CERTIFY, That I attended deceased from Mar 31, 1929, to Apr. 1, 1929, that I last saw her alive on March 31, 1929 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) H. O. Stonesifer, M. D.

, 19 (Address) 9 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: 3 • 1929

20 UNDERTAKER: H. M. Cook — ADDRESS: 12 E. Saratoga St.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44671

CERTIFICATE OF DEATH

E 44671

186-703

1-PLACE OF DEATH

City of Baltimore: (No.) City Hospital St., 11-24 Ward

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maurice W Baird

(a) RESIDENCE NO. 805 N Chester St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Amelia Baird

6 DATE OF BIRTH (month, day, and year) Aug. 16, 1890

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	38	7	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Ice Dealer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Self

9 BIRTHPLACE (city or town)
(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Charles C Baird

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Anna Litchfield

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore Md

14 Informant Anna Litchfield
(Address) 805 N Chester St

Filed APR 3 - 1929 C. HAMPSON JONES, M. D.
Registrar

Par

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 2 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Dil
Multiple Fractures
(Duration) yrs. mos. 1 hr.
CONTRIBUTORY (Secondary) Shock
(Duration) yrs. mos.

18 Where was disease contracted? If not at place of death Rocks River Md

Did an operation precede death? Yes Date of Apr 1/29

Was there an autopsy? No

What confirmed diagnosis? Inquiry

(Signed) J C Staats M. D.

, 19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Apr 5 1929
20 UNDERTAKER Wm Cook	ADDRESS 1217 St Paul St

Important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 Bks.

E 44672

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44672

CERTIFICATE OF DEATH.

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1110 White Oak Groove St.) (11-2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Susan Smith

(Residence in Baltimore: No. 1116 Bolton St. St.) (Life yrs., mos., ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. F.

4-COLOR OR RACE. C

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, May 31st, 1863 (Month) (Day) (Year)

7-AGE, 66 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country), Baltimore Md.

PARENTS.

10-NAME OF FATHER, Joseph Smith

11-BIRTHPLACE OF FATHER (State or Country), Md.

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country), Unknown.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Joseph Hankins

(Address) 1110 White Oak Grove

15- APR 3 1929 C. HAMPSON JONES, M. D. 191 Per Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 1-, 1929 (Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Mar-26 1929, to April 1- 1929, that I saw her alive on March 31 1929, and that death occurred, on the date stated above, at 2-30 P. m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Influenza

(Duration) yrs. mos. 7 ds.

(Signed) H. Gibson Porter M. D.

4-2, 1929 (Address) 422 Roland Ave.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt. Calvary — DATE OF BURIAL, Apr. 3, 1929

20-UNDERTAKER Wm. R. A. Elliott — ADDRESS 1425 Ashland

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44673 — CERTIFICATE OF DEATH — 46 — E 44673

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 540 E. 22nd St. ST., 9-46 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Amelia J. Haugh

(a) RESIDENCE NO. 540 E. 22Nd. St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. 3 mos. 7 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles D. Haugh

6 DATE OF BIRTH (month, day, and year) Dec. 25, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

10 NAME OF FATHER John I. Kuhn.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Mary Wiseman.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) France

14 Informant Mr. Joseph F. Haugh
(Address) 540 E. 22nd. St.

15 Filed 3-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept, 19 28, to April 2, 19 29, that I last saw her alive on April 2, 19 29, and that death occurred, on the date stated above, at 3.30 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency and Senility.

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Uterus

(duration) yrs. 9 mos. ds.

18 Where was disease contracted If not at place of death? ?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Thomas J. Haller M. D.

, 19 (Address) 532 E. 22nd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	April 4 29
20 UNDERTAKER	ADDRESS
Henry W. Meares & Son	805 N. Calvert St.

Spec.—2-29-28—L. F. S.—500 Blks.

E 44674

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 44674

1—PLACE OF DEATH

REGISTERED NO. 13-52

CITY OF BALTIMORE: (No. 3739 Elm Ave ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jacob F. Shearer.

(a) RESIDENCE NO 3739 Elm Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Kate Sarah Shearer

6 DATE OF BIRTH (month, day, and year): Oct 30 1841

7 AGE: Years 87 | Months 5 | Days 2 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): md.

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant: Jacob F. Shearer

(Address) 3739 Elm Ave

15 Filed 3-29-1929 C. HAMPSON JONES, M. D. Registrar

Per Kelly

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 1/29.

17 I HEREBY CERTIFY, That I attended deceased from Mar 31, 1929, to Apr 1, 1929, that I last saw h[illegible] alive on Mar 31, 1929 and that death occurred, on the date stated above, at 2.20 p. m.

The CAUSE OF DEATH* was as follows:

Senile Myocarditis

Indefinite (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Routine

(Signed) Edith Widdowson, M. D.

Apr 1, 1929 (Address) 830 W 36 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Baltimore	Apr 4 1929
20 UNDERTAKER	ADDRESS
Ehrenworth Lon	3617 Chestnut Ave

Cor.—10-10-29—A Co.—100 Bks.

E 44675

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-09

E 44675

1-PLACE OF DEATH

City of Baltimore: (No. St. Joseph Hospital St., 5-6 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robert Redwing

(a) RESIDENCE NO. 717 E. Fayette St St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. about 10 mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	32			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work unknown
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Unknown

PARENTS

10 NAME OF FATHER "

11 BIRTHPLACE OF FATHER (city or town) "
(State or country)

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) "
(State or country)

14 Informant John T. McCaslin
(Address) 135 E. Baltimore St

15 Filed 19 THOMPSON JONES, M. D.
Registrar

APR 3 - 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192 Mar 28/29

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobular Pneumonia

(duration) yrs. about 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. McCaslin, M. D.

4/1/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY

DATE OF BURIAL 19

20 UNDERTAKER Com. Hesteiner Health

ADDRESS APR 1 - 1929

Dr. Wm. E. Woodall

Important. See instructions on back of certificate.

Spec.—1-10.21—M&T—1500 Bks.

Green

E 44676

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 E 44676

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1502 Madison ave. ST. 14-20 WARD)

2-FULL NAME Sarah Green

(a) RESIDENCE NO. 1502 Madison ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, ~~or Divorced (write the word)~~
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Green

6 DATE OF BIRTH (month, day, and year) Aug. 10, 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 070

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) West River Md.

PARENTS

10 NAME OF FATHER John Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Harriet Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Ella Cooper (Address) 1502 Madison ave.

15 Filed APR 3 - 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30 1929

17 I HEREBY CERTIFY, That I attended deceased from Jany 29, 1929, to March 30, 1929, that I last saw h[illegible] alive on March 30, 1929 and that death occurred, on the date stated above, at 11.45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma (Left Arm)

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) W. S. Smith, M. D.

, 19 (Address) 129 W. Lee St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL April 4 1929

20 UNDERTAKER Thomas E. Kelson

ADDRESS 1303 Pennsylvania Ave

THIS IS very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 44677 (90) E 44677

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 4000 Norfolk ave St. 5-65 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachel Markowitz

(a) RESIDENCE NO. 4000 Norfolk ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): Widowe

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Late Jacob

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE: Years 86 Months — Days — IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Russia (State or country)

PARENTS

10 NAME OF FATHER: Samuel M. Bookholter

11 BIRTHPLACE OF FATHER (City or town): (State or country) Russia

12 MAIDEN NAME OF MOTHER: Fannie

13 BIRTHPLACE OF MOTHER (city or town): (State or country) Russia

14 Informant: M. Markowitz

(Address) 4000 Norfolk ave

C. HAMPSON JONES, M. D.

Filed APR 3 1929, 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 2nd 1929

17 I HEREBY CERTIFY, That I attended deceased from March 16th, 1929, to April 2nd, 1929, that I last saw h alive on April 1st, 1929, and that death occurred, on the date stated above, at 9.30 a m.

The CAUSE OF DEATH* was as follows:

arterio Sclerosis Chronic myocarditis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) R. G. Nicholson M. D.

April 2, 1929 (Address) 2230 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Herring Run — Date of Burial 4/3 1929

20 UNDERTAKER: Sol Levinson & Bro — ADDRESS 1127 E Balto st

very important. See instructions on back of certificates.

Spec.—2-29-25—L. F. S.—500 Bks.

E 44678

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44678

CERTIFICATE OF DEATH

94-001

1—PLACE OF DEATH

REGISTERED NO. 15561

CITY OF BALTIMORE: (No.) 3614 (STREET) Fairview Ave (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harry Clifford McIntire

(a) RESIDENCE NO. 3614 Fairview Ave. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Grace M. McIntire

6 DATE OF BIRTH (month, day, and year): June 15 1872

7 AGE: Years 56 | Months 9 | Days 17 | If LESS than 1 day, hrs or min. 16

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Garage

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Self. Phila Pa

9 BIRTHPLACE (city or town) (State or country): Phila Pa

10 NAME OF FATHER: Wm McIntire

11 BIRTHPLACE OF FATHER (city or town) (State or country): Phila Pa

12 MAIDEN NAME OF MOTHER: Josephine Young

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Phila Pa

14 Informant: Mrs Grace M. McIntire

(Address) 3614 Fairview Ave.

15 Filed 1929 G. HAMPSON JONES, M. D. Registrar

R 3 - 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 1, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 1928 to April 1 1929, that I last saw living on April 1 1929, and that death occurred, on the date stated above, at 11.45 P m.

The CAUSE OF DEATH* was as follows:

Art. Hypertension. Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Emerson Thomas, M. D.

3/8, 1929 (Address) W.O. Med. Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cem.

DATE OF BURIAL: Apr. 3, 1929

20 UNDERTAKER: Wm J Tickner Sons

ADDRESS: North & Pa

Spec.—1-12-23—M&T—500 Bks.

E 44679

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44679

CERTIFICATE OF DEATH.

REGISTERED NO. 112

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 416 N. Carey ST. 19-16 WARD)

2-FULL NAME Francis M. Tubman

(a) RESIDENCE NO. 416 N. Carey ST., ... WARD
(Usual place of abode)
Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Wh.	

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jany. 17/26

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	3	2	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ....
(b) General nature of industry, business, or establishment in which employed (or employer) ....
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Geo. A. Tubman

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Ethel E. Dennis

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Mrs Ethel E. Tubman
(Address) 416 N. Carey St

15 Filed Apr 4 1929, 19 C. HAMPSON JONES, M. D.
Registrar
Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 1 1929

17 I HEREBY CERTIFY, That I attended deceased from Apr. 1 1929, to Apr. 1 1929, that I last saw him alive on Apr. 1 1929, and that death occurred, on the date stated above, at 11.57 P m.

The CAUSE OF DEATH* was as follows:

Convulsions due to acute meningitis

6 hrs.
(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Bronchial pneumonia 2 days
(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? ....

Did an operation precede death? No Date of ....

Was there an autopsy? No

What test confirmed diagnosis? ....

(Signed) E. Hamill, M. D.

Apr 2, 1929 (Address) 1605 W. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: April 4 1929

20 UNDERTAKER: J. Nat. Syfer — ADDRESS: 1600 W. North Ave

Spec.—2-20-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44680

CERTIFICATE OF DEATH

7-09

E 44680

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 5000½ Toone ST. 26-37 WARD)

2—FULL NAME Frank Martens

(a) RESIDENCE NO. 5000½ Toone ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? 62 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catharine Martens

6 DATE OF BIRTH (month, day, and year) Nov. 28-1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	4	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dairy-Man (Retired)

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Catharine Martens

(Address) 5000½ Toone St

15 Filed APR 3 1929 19 C. HAMPSON JONES, M. D. Registrar

Reg. No. 466

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1-1929

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1929, to April 1, 1929, that I last saw h. alive on April 1, 1929 and that death occurred, on the date stated above, at 8 25 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) Gradual yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) Gradual yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Horace B. Tatlow, M. D.

4/2, 1929 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oaklawn Cemetery	April 4 1929
20 UNDERTAKER	ADDRESS
George W. Zirkle	1737 E. Eager St

Spec.—2-29-28—L. F. S.—500 Bks.

E 44681

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

86 E 44681

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 119 S. Bouldin ST. H-V WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mamie Boog

(a) RESIDENCE NO. 119 S. Bouldin ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Boog.

6 DATE OF BIRTH (month, day, and year) Dec. 26. 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	3	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General natnre of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

10 NAME OF FATHER George Rohrig

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Fogel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John Boog

(Address) 119 S. Bouldin St.

Filed APR 3 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1-1929

17 I HEREBY CERTIFY, That I attended deceased from March 22, 1929, to April 1, 1929, that I last saw her alive on April 1, 1929 and that death occurred, on the date stated above, at 7.45 P m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? ~ Date of

Was there an autopsy? ~

What test confirmed diagnosis? Clinical

(Signed) Calet V. Tilley, M. D.

April 2, 1929 (Address) 100. S. Patterson Park ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oaklawn Cemetery	April 5 1929
20 UNDERTAKER W. G. George W. Zurkler	ADDRESS 737 E. Eager St

Cor.—12-9-25—A Co.—200 Bks.

E 44682 HEALTH DEPARTMENT—CITY OF BALTIMORE

11-002

CERTIFICATE OF DEATH.

E 44682

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph's Hospital 26-41 Ward)

2-FULL NAME William C. Sweigart

(a) RESIDENCE NO. 4145 Eierman Ave. St. _____ Ward _____
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella Sweigart

6 DATE OF BIRTH (month, day, and year) Aug. 12, 1882

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	46	7	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work R.R. Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Bethlehem Steel Co.

9 BIRTHPLACE (city or town) _____

(State or country) Westminster, Md.

PARENTS

10 NAME OF FATHER Joshua Sweigart

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Westminster, Md.

12 MAIDEN NAME OF MOTHER Lucinda M. Stone

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Westminster, Md.

14 Informant Mrs. Lucinda Peltekian

(Address) 817 Hamilton Terrace

15 [illegible] 19 [illegible] HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 2, 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Myocardial failure

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) History Influenza 4 or 5 Weeks ago (Duration) ____ yrs. ____ mos. ____ ds.

(Signed) [signature] M. D.
(Coroner)

4/3/29 19 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Westminster Cemetery Westminster Md. Date of Burial: April 4 1929

20 UNDERTAKER: John F. Penny ADDRESS: 715 Lexington St

Very Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 44683 HEALTH DEPARTMENT—CITY OF BALTIMORE E 44683

CERTIFICATE OF DEATH

101-00

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 508 Longwood ST. 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emma Ridgway Allen

(a) RESIDENCE NO. 508 Longwood ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Frederick Allen

6 DATE OF BIRTH (month, day, and year) May 1 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	50	10	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Mary Jane Pelgar

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Wm F. Allen Husb
(Address) 508 Longwood St

15 FILED APR 3 - 1929 H. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30 29

17 I HEREBY CERTIFY, That I attended deceased from March 27 1929, to March 30, 1929, that I last saw h alive on March 30, 1929 and that death occurred, on the date stated above, at 1.45 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

3½ days (duration) 0 yrs. 0 mos. 3½ ds.

CONTRIBUTORY (Secondary) Dyspnea

(duration) yrs. mos. 3½ ds.

18 Where was disease contracted if not at place of death? K

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Edward Fisher, M. D.

Apr 2 1929 (Address) 1612 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem.

DATE OF BURIAL 4/3 1929

20 UNDERTAKER Byron Knight 1218 McCulloh St

ADDRESS

Spec.—1-12-23—M&T—500 Blks.

E 44684 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 ~ E 44684

CERTIFICATE OF DEATH.

REGISTERED NO.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No. Monument ST. 18-16 WARD)

2-FULL NAME Kalman Cohen

(a) RESIDENCE NO. 1019 W. Baltimore ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Kalman Cohen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rutta —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant David Cohen
(Address) 648 W. Baltimore St

15 Filed ..... 19 ..... HAMPSON JONES, M. D. Registrar

PR 3 - 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4 - 3 1929

17 I HEREBY CERTIFY, That I attended deceased from March 20, 1929, to April 3, 1929, that I last saw him alive on April 3, 1929, and that death occurred, on the date stated above, at 1:12 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Arterio-Sclerotic Cardio-Vascular Disease - Cerebral Hemorrhage (duration) yrs. 4 days ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab. & Clinic

(Signed) Herman Cohen, M. D.

, 19 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale — DATE OF BURIAL 4-3- 1929

20 UNDERTAKER Jos Levin, ADDRESS 1424 E Balto

Spec.—2-29-28—L. F. S.—500 Bks.

E 44685

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 44685

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 952 (ST.) Harlem Ave (WARD) 16-23

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Smith

(a) RESIDENCE NO. 952 (ST.) Harlem Ave WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1886

7 AGE: Years 43 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): London.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

10 NAME OF FATHER: John Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Ellen Payne

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Carrie Cartins

(Address) 953 Harlem Ave.

15 Filed 5-1925 19 H. THOMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 3-30-1929

17 I HEREBY CERTIFY, That I attended deceased from August, 1928, to 3-30-, 1929.

that I last saw h.. alive on 3-29-, 1929

and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) a few hours yrs. mos. ds.

CONTRIBUTORY (Secondary) High B.P. Nephritis

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. H. Thompson Jones, M. D.

4-2, 1929 (Address) 117 W. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem | DATE OF BURIAL: 4/3/29

20 UNDERTAKER: Samuel A. Wesley | ADDRESS 5318 Belair Rd

Spec.—2-29-28—L. P. S.—500 Bks.

E 44686

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 44686

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 504 (St.) Myrtle Ave (WARD) 17-16

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Isaac Gross

(a) RESIDENCE NO. 504 (St.) Myrtle Ave (WARD)

(Usual place of abode)

Length of residence in city or town where death occurred 2nd yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie L. Gross

6 DATE OF BIRTH (month, day, and year) Feb 22 — 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	64	1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer City

9 BIRTHPLACE (city or town) (State or country) Hunterville Md

10 NAME OF FATHER James Gross

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Carrie L. Gross

(Address) 504 Myrtle Ave

15 Filed 4-3-1929, C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30 1929

17 I HEREBY CERTIFY, That I attended deceased from March 28, 1929, to March 30, 1929, that I last saw h living alive on March 30, 1929 and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted? If not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical exam only.

(Signed) S Marcus, M. D.

19 (Address) 2816 Baker St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Zion Cem	4/3 1929

20 UNDERTAKER Samuel Hemsley & Bro

ADDRESS 1798 Bolton

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44687 46 E 44687

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 27-44

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 2907 Silsa ave ST. (WARD) 27

2—FULL NAME Louisa C. Heck

(a) RESIDENCE NO. 2907 Silsa ave ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Stephen Heck

6 DATE OF BIRTH (month, day, and year): Jan 18/1850

7 AGE: Years 79 | Months 3 | Days 13 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

10 NAME OF FATHER: — — Jensen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: "

13 BIRTHPLACE OF MOTHER (city or town) (State or country): "

14 Informant: Mrs. Edw. Krautter

(Address) 2907 Silsa ave

15 Filed 3 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Mar. 31/29

17 I HEREBY CERTIFY, That I attended deceased from 3-1-29 to 3-31-29 that I last saw h[illegible] alive on Mar 31/29 and that death occurred, on the date stated above, at 4:05 a.m.

The CAUSE OF DEATH* was as follows:

Cancer of Vagina & Rectum

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary): Bad Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Surgical

(Signed) J. [illegible] M. D.

4-2 19 27 (Address) 800 N. Dallas

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Mem

DATE OF BURIAL: 4/3/1929

20 UNDERTAKER: Philip Henrig

ADDRESS 2016 Orleans St.

Spec.—2-29-28—L. F. S.—500 Bks.

E 44688 HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

E 44688

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 16-69

CITY OF BALTIMORE: (No. 613 Bentalou St ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James F. Mc Shane

(a) RESIDENCE NO. 613 Bentalou St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced, (write the word): Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of: Teddie Mc Shane

6 DATE OF BIRTH (month, day, and year): Feb. 20, 1875

7 AGE: Years 54 | Months 1 | Days 12 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Engineer

(b) General nature of industry, business, or establishment in which employed (or employer): Mechanical 030

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto.

10 NAME OF FATHER: Dr. J. F. Mc Shane

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto.

12 MAIDEN NAME OF MOTHER: Mary Bradley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto.

14 Informant: Teddie Mc Shane

(Address) 613 Bentalon st.

Filed 3 1929 C. HAMPSON JONES, M. D. Registrar

Dec

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-2-29

17

I HEREBY CERTIFY, That I attended deceased from March 15 1929 to April 2nd 1929, that I last saw him alive on April 2nd 1929 and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Cebreal Paralysis

Hemorrhage of Right Brain

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary): Hemiplegia of Left Brain

(duration) yrs. mns. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Paralysis

(Signed) Thos. H. Chilcoat, M. D.

19 (Address) 2300 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Louden Park	April 4, 1929
20 UNDERTAKER: Geo A. Moan	ADDRESS 3000 E. Balto St.

Spec.—1-12-23—M&T—500 Blks.

E 44689 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH. X 129 **E 44689**

1-PLACE OF DEATH West Baltimore General. REGISTERED NO.

CITY OF BALTIMORE: (No. 16-68 STREET) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Emma Merryman.

(a) RESIDENCE NO. Old Frederick Road, Catonsville WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: John Merryman.

6 DATE OF BIRTH (month, day, and year): ~~May~~ 29 1861

7 AGE: Years 67. Months 4 Days 4 If LESS than 1 day, hrs or min. 5

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF ~~FATHER~~: Abel

11 BIRTHPLACE OF ~~FATHER~~ (city or town) (State or country): France

12 MAIDEN NAME OF MOTHER: Margaret Lonchmary

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: John Merryman

(Address): Catonsville Md

Filed 3-1929 C. HAMPSON JONES, M. D. Registrar

Per RWP

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 3, 1929.

17 I HEREBY CERTIFY, That I attended deceased from March 29. 1929. to April 3 1929.

that I last saw h~~er~~ alive on April 3. 1929

and that death occurred, on the date stated above, at 7:30 a. m.

The CAUSE OF DEATH* was as follows:

Cardio. Renal Vascular Disease

Hypertensive

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary): Uremia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Paul Schenken, M. D.

4/3. 1929 (Address) West Balto. General.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cem

DATE OF BURIAL: Apr 5 1929

20 UNDERTAKER: Easton & Sons

ADDRESS: Ellicott City

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44690 CERTIFICATE OF DEATH 31 E 44690

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST. T.B. WARD) REGISTERED NO. 17524

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thermon Cline

(a) RESIDENCE NO. 580 W. Biddle st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Albert Cline

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Mamie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Hospital Records

(Address)

15 Filed APR 3 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 30, 1929

17

I HEREBY CERTIFY, That I attended deceased from Nov. 26, 1928, to March 30, 1929, that I last saw him alive on March 30, 1929 and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Artificial pneumothorax

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical and lab.

(Signed) Henry Smith, M. D.

3-31 19 29 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

UNIVERSITY OF MARYLAND

Commissioner Health.

APR 3 - 1929

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

44691

CERTIFICATE OF DEATH

31 E 44691

1—PLACE OF DEATH

REGISTERED NO. 17-16

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST., T. B. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sam Hunter

(a) RESIDENCE NO. 738 Pennsylvania ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Separated

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10 NAME OF FATHER John H. Hunter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgia

12 MAIDEN NAME OF MOTHER Adelia Ford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Georgia

14 Informant Hospital Records

(Address)

Filed APR 3 - 1929 JAMESON JONES, M. D. Registrar

Rec. 3-31

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31, 1929

17 I HEREBY CERTIFY, That I attended deceased from January 19 29, to March 31 29,

that I last saw him alive on March 31, 29

and that death occurred, on the date stated above, at 3.30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical and lab.

(Signed) Henry Smith, M. D.

3-31. 19 29 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
UNIVERSITY OF MARYLAND	19
20 UNDERTAKER Commissioner of Health.	ADDRESS APR 3 - 1929

Spec. No. 5. WOODALL

Spec.—2-29-28—L. F. S.—500 Blks.

Villa

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44692

CERTIFICATE OF DEATH

44 E 44692

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 607 E 35th St ST. 9-47 WARD)

2—FULL NAME Rosa Villa

(a) RESIDENCE NO. 607 E 35th St ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if foreign birth 27 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F | 4 COLOR OR RACE: W | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Cesare Villa

6 DATE OF BIRTH (month, day, and year): Sept 23 1881

7 AGE: Years 47 | Months 6 | Days 9 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home Wife

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER: Carlo Pasquarelli

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Rosa Pizzuto

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: Jessie Pasquarelli
(Address) 607 E 35th St

15 Filed APR 3 - 1929 S. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 2 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb. 2, 19 29, to April 2, 19 29, that I last saw h alive on March 31, 19 29 and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma 2 mos

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(doration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Emma L. Passano, M. D.

4.2., 1929 (Address) 514 Druid Lane

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	April 4 1929
20 UNDERTAKER	ADDRESS
M. W. E. Duggan	3121 Eastern Ave

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44693

CERTIFICATE OF DEATH.

74-201

REGISTERED NO. E 44693

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Franklin Square Hospital St. 14-26 Ward)

2-FULL NAME Franklin B Williams

(a) RESIDENCE NO. 1307 W. Fayette St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 1/2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martha E—

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	55	2	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Contractor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md

10 NAME OF FATHER Benj William

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

PARENTS

14 Informant John Williams

(Address) 3017 Biddle Lane

15 Filed APR 7 1929

C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/2 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

a Coronary Thrombosis

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) Chas H Woode M. D.

(Coroner) Brooklyn Md

4/2, 1929 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the state.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Frostburg Md. Date of Burial Apr. 4 1929

20 UNDERTAKER Harry H. Weitzke ADDRESS 1531 W. Lombard St.

Very Important. See instructions on back of certificate.

R3-1929

Spec.—1-12-23—M&T—500 Bks.

Elaine E Lambert

E 44694

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

E 44694

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Baltimore

CITY OF BALTIMORE: (No. 531 Cordelia av ST. 27-55 WARD)

2-FULL NAME Elsie Elizabeth Lambert

(a) RESIDENCE No. 531 Cordelia av ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 16 1925

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	3	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Robert V Lambert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Katherine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Robert V Lambert

(Address) 531 Cordelia av

15 Filed 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2 1929

17 I HEREBY CERTIFY, That I attended deceased from April 1st, 1929, to April 2nd, 1929, that I last saw her alive on April 2nd, 1929 and that death occurred, on the date stated above, at 1 30 P m

The CAUSE OF DEATH* was as follows:

Bronchial pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Cardiac insufficiency

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) J. J. Burton, M. D.

, 19 (Address) 214 Centerstown Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery — DATE OF BURIAL 4/4 1929

20 UNDERTAKER Josiah Offer — ADDRESS 1600 Pratt

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44695

CERTIFICATE OF DEATH

29

E 44695

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 625 W. Biddle St. (WARD) 7

2—FULL NAME Lucy Ware

(a) RESIDENCE NO. 625 W. Biddle St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	C.	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Humphrey Medley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Sarah Jimson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Goldie Green

(Address) 625 W. Biddle St.

15 Filed APR 3 - 1929, 19

C. HAMPSON JONES, M. D.

Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 28, 1929, to April 1, 1929, that I last saw h. alive on March 31, 1929 and that death occurred, on the date stated above, at 6.40 a. m.

The CAUSE OF DEATH* was as follows:

Endocarditis + nephritis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) R. Eaker, M. D.

, 19 (Address) 625 Dolphin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Cemetery	Apr. 3 1929
20 UNDERTAKER	ADDRESS
Mrs. R. G. Elliott	1725 Ashland Ave

Cor.—12-9-25—A Co.—200 Bks.

Grese

HEALTH DEPARTMENT—CITY OF BALTIMORE

105

E 44696

CERTIFICATE OF DEATH.

E 44696

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2301 Lanvale St. 10-64 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry W Frase

(a) RESIDENCE NO. 2301 Lanvale St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Anna Frase

6 DATE OF BIRTH (month, day, and year) March 10 1862

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs, or.....min.
	67	0	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md

PARENTS

10 NAME OF FATHER Frank Frase

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Elizabeth Fortenberry

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs. Chas Frase

(Address) 2301 Lanvale St

Dec 3 1929 C. HAMPSON JONES, M. D. Registrar

Per C.C.J.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/1 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asthma

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) Chas H Brosius M. D.
(Coroner)

4/1, 1929 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem. Date of Burial Dec 4 1929

20 UNDERTAKER Jno. W. Little 2700 Edmondson Ave

Very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44697 — CERTIFICATE OF DEATH — 1-001 — E 44697

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 1913 Harlem Ave. ST. 16-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Reamy Leake,

(a) RESIDENCE NO. 1913 Harlem Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Male	White	Married

a If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Della Fannie Leake,

6 DATE OF BIRTH (month, day, and year) January 28. 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Printing Business

(b) General nature of industry, business, or establishment in which employed (or employer) 063

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER James G. Leake,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Carrie Reamy,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs Della F Leake

(Address) 1913 Harlem Ave

15 Filed R 3 1929

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY, That I attended deceased from Mar 5 1929 to Apr 1 1929

that I last saw him alive on Apr 1 1929

and that death occurred, on the date stated above, at 1-15 P m.

The CAUSE OF DEATH* was as follows:

Typhoid fever com-
plicated by septicaemia

(duration) yrs. mos. 40 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood test

(Signed) [illegible] M. D.

Apr 2 1929 (Address) 2105 Eha

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ Loudon Park — DATE OF BURIAL 19

20 UNDERTAKER Geo W Little — ADDRESS

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44698

CERTIFICATE OF DEATH.

89

E 44698

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 409 Calon av St. 70-70 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dan'l Hoffman

(a) RESIDENCE NO. 409 Calon av St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Wht

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Carrie Hoffman

6 DATE OF BIRTH (month, day, and year): Mar 18 1856

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	73		15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Engineer

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER: Jos. L. Hoffman

11 BIRTHPLACE OF FATHER (city or town): Germany

(State or country)

12 MAIDEN NAME OF MOTHER: Gustmann

13 BIRTHPLACE OF MOTHER (city or town): Baltimore

(State or country)

14 Informant: Carrie Hoffman

(Address) 409 Calon

15 Filed _____ 19____ C. HAMPSON JONES, M. D. Registrar

By _____

3 - 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/2 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) Chas. H. Brooke M. D.

(Coroner)

4/2, 1927 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. Date of Burial: April 4, 1929

20 UNDERTAKER: C. W. Dill. ADDRESS 3109 Frederick Ave.

very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

Dr Shannon Fulton & Horton.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44699

CERTIFICATE OF DEATH

101-001

E 44699

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 907 N. Bentalou ST., 16-68 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Eva Geddes

(a) RESIDENCE NO. 907 N. Bentalou ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

3a If married, widowed, or divorced HUSBAND of (or) WIFE of William J. Geddes

6 DATE OF BIRTH (month, day, and year) Feb 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

10 NAME OF FATHER John Vance

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Cecilia Geddes

(Address) 907 N. Bentalou St

Filed 3-1929 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 2. 1929

17 I HEREBY CERTIFY, That I attended deceased from Mar 31, 1929, to Apr 2, 1929, that I last saw her alive on Apr. 2, 1929 and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

I Pneumonia (right Lobar)

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Chr. Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) George E. Shannon, M. D.

Apr 3. 1929 (Address) 700 N. Fulton Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn County

DATE OF BURIAL 4 6 1929

20 UNDERTAKER J. M. Cook

ADDRESS 1241 Edmondson Av

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44700

CERTIFICATE OF DEATH

161-001

E 44700

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 529 Mc Mechen ST. 17-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Girl Dyson

(a) RESIDENCE NO. 529 Mc Mechen ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	black	

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 2, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) 529 Mc Mechen St
(State or country)

PARENTS

10 NAME OF FATHER Joseph Dyson

11 BIRTHPLACE OF FATHER (city or town) Charles City
(State or country) Md.

12 MAIDEN NAME OF MOTHER Lucile Neil

13 BIRTHPLACE OF MOTHER (city or town) Charles City
(State or country) Md

14 Informant Father

(Address) 529 Mc Mechen St

15 Filed 3-1929 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-2-29.

17 I HEREBY CERTIFY, That I attended deceased from April 2, 1929, to April 2, 1929

that I last saw h.. alive on April 2, 1929

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. Alexander Howes M. D.

, 19 (Address) 1516 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19 1929
20 UNDERTAKER	ADDRESS

JOHNS HOPKINS HOSPITAL

Commissioner Health

Spec.—2-29-28—L. F. S.—600 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44701

CERTIFICATE OF DEATH

84 E 44701

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 929 Birney St. ST. 1-3 WARD)

2—FULL NAME William Kendzejewski

(a) RESIDENCE NO. 929 Birney St. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jozefa kendezjewski

6 DATE OF BIRTH (month, day, and year) Feb. 1 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 0

(b) General nature of industry, business, or establishment in which employed (or employer) Labor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

10 NAME OF FATHER Felix Kendzejewski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

PARENTS

14 Informant Josefa Kendzejewska

(Address) 929 Birney St

15 Filed 4-2-1929 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 3, 1925, to April 3, 1929, that I last saw h alive on March 7, 1929 and that death occurred, on the date stated above, at 4.30 a.m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Chas. L. Kier, M. D.

4/2/29, 19 (Address) 428 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus	April 6 1929
20 UNDERTAKER	ADDRESS
John N. Welch	401 S. Chester St

Spec.—2-29-28—L. F. S.—500 Bks.

E 44702

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 44702

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 107 W. 27th St. ST. 12-50 WARD)

2—FULL NAME Mrs. Ellen W. Saffran

(a) RESIDENCE NO. 107 W. 27th. St. ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? about 35 yrs.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr. Curt C. Saffran

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in whirh employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mr. Karl A. M. Scholtz

(Address) 306 St. Paul St.

15 Filed 4-3 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3, 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb 11th, 1929, to Apr. 2nd, 1929, that I last saw h Er alive on Apr. 3nd, 1929, and that death occurred, on the date stated above, at 1.15 A m.

The CAUSE OF DEATH* was as follows:

Paralysis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical Exam.

(Signed) Gunyon E Cross, M. D.

4. , 19 (Address) 28 W 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	April 6 1929
20 UNDERTAKER	ADDRESS
Henry W. Meurs & Son	805 N. Calvert St.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44703 — CERTIFICATE OF DEATH. — E 44703

REGISTERED NO.

1-PLACE OF DEATH: Church Home & Infirmary

City of BALTIMORE: (No. 126 N Broadway St., 6-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr William Lynch.

(a) RESIDENCE NO. Sparrow Point R.F.D. Maryland.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If ~~married, widowed, or divorced~~ HUSBAND of (or ~~WIFE of~~) Elenora Lynch

6 DATE OF BIRTH (month, day, and year) Feb 11 - 156?

7 AGE: Years 62 | Months 1 | Days 19 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of Industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland.

PARENTS

10 NAME OF FATHER William Lynch.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Catherine Buck.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) unknown

14 Informant William H. Lynch.
(Address) Rose Ave, Balto. Co. Md

15 Filed 1929 — C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb 2 1929, to Apr 1 1929, that I last saw h[illegible]ative on Apr 1 1929, and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:
Mitral Insufficiency
"
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Cardiac Decompensation
(duration) 6 + yrs. mos. ds.

18 Where was disease contracted
If not at place of death
Did an operation precede death? No Date of
Was there an autopsy? Yes
What test confirmed diagnosis? Autopsy & Clinical Findings
(Signed) D. B. Peeler, M. D.
, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery — Date of Burial Apl 4 1929

20 UNDERTAKER: Hughes & Jones — ADDRESS: Ford & Fody

Any Employee. See instructions on back of certificate.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44704

CERTIFICATE OF DEATH

+ 101-001

E 44704

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Md. General Hospital St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Laura V. Carr.

(a) RESIDENCE NO. Spencerville, Md. St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ed. H. Carr.

6 DATE OF BIRTH (month, day, and year): Mar 7, 1864

7 AGE: Years 65 Months 0 Days 26 27

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife 27

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER: Franklin Wilson

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland.

12 MAIDEN NAME OF MOTHER: Caroline Harding

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland.

14 Informant ... (Address) Hospital Records.

15 Filed ... Registrar

APR 4 - 1929 C. HAMPSON JONES, M. D.

per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

4-3-29

17 I HEREBY CERTIFY, That I attended deceased from 3-26-, 19 29, to 4-3, 19 29, that I last saw her alive on 4-3 — 19 29, and that death occurred, on the date stated abnve, at 11 20 p. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Emphysema.

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? yes Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Spencerville Md — Date of Burial 4/6/29

20 UNDERTAKER: Lloyd Kaiser — ADDRESS Laurel Md.

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 44705

HEALTH DEPARTMENT—CITY OF BALTIMORE

56 001

56 E 44705

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No. Monument St. 2435 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Hannah Meisel

(a) RESIDENCE NO. 1612 E. Fort Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mes. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Solomon

6 DATE OF BIRTH (month, day, and year): 1871

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
58	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Abraham Blum

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Sophia Stern

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Solomon Meisel

(Address): 1612 E Fort ave

15 Filed 4-1929 By HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/3 1929

17

I HEREBY CERTIFY, That I attended deceased from 11/26/28, 1928, to 4/3/29, 1929, that I last saw h[illegible] alive on 4/3/29, 1929, and that death occurred, on the date stated above, at 2:20 p.m.

The CAUSE OF DEATH* was as follows:

Pernicious Anemia

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? S

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Lab. & Clinic

(Signed) Herman Chor, M. D.

4/3 1929 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Nat. New Washington Rd

DATE OF BURIAL: 4/4 1929

20 UNDERTAKER: Sol Levinson & Bro

ADDRESS: E. B[illegible]

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44706

CERTIFICATE OF DEATH

101-001

REGISTERED NO. E 44706

1-PLACE OF DEATH

City of Baltimore: (No. Johns Hopkins Hospital St. 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John L. Wade

(a) RESIDENCE NO. 1200 E. Lexington St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Florence Wade

6 DATE OF BIRTH (month, day, and year) March 5/1891

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	38	0	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Rigger
(b) General nature of industry, business, or establishment in which employed (or employer) do
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Denmark

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) "
(State or country)

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) "
(State or country)

14 Informant Florence Wade
(Address) 1200 E. Lexington St

15 Filed ....., 19.... HAMPSON JONES M. D.
Registrar

4 1929 Mar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 1/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia
Acute Meningitis
(Autopsy at Hopkins)

(duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary)

(duration) ..yrs. ..mos. ..ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) J. H. Wilson, M. D.

4/3/29 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery — DATE OF BURIAL 4/4 1929

20 UNDERTAKER Sol Thomson & Bro — ADDRESS 1127 E. Balto St

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 44707

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 44707

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 900 W Lombard. ST. (WARD) 18-29

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Herbert Smith.

(a) RESIDENCE NO. 900 W Lombard ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. 30 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 4th 1928.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		3	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer /

9 BIRTHPLACE (city or town) (State or country) Balto Md.

10 NAME OF FATHER Davis E. Hall.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mrs. Davis E Hall

(Address) 900 W. Lombard St

Filed 4-4-1929 C. HAMPSON JONES, M. D. Registrar

By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 3rd 1929.

17 I HEREBY CERTIFY, That I attended deceased from Apr. 2 , 1929, to Apr. 3 , 1929, that I last saw him alive on Apr. 3. , 1929, and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Acute Broncho-Pneumonia

CONTRIBUTORY (Secondary) Whooping Cough (duration) — yrs. 1 mos. — ds.

(duration) — yrs. — mos. 21 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no. Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Physical Exam Dr.

(Signed) J. Chas. Horton, M. D.

4/3/29 (Address) 882 W. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem.

DATE OF BURIAL April 4th 1929

20 UNDERTAKER J. J. Cowan & Son.

ADDRESS 901 Baltimore

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44708

CERTIFICATE OF DEATH

X 65-001

E 44708

1—PLACE OF DEATH University Hospital. REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 4-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Bessie Cox

(a) RESIDENCE NO. 108 E. Susquehanna ST., ave Towson Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Divorced.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Telephone operator

(b) General nature of industry, business, or establishment in which employed (or employer) 609

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Reuben Whitener

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C.

14 Informant Hospital Records.

(Address)

15 Filed 4-6 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3rd 1929.

17

I HEREBY CERTIFY, That I attended deceased from Mar 27th, 1929, to April 3rd 1929,

that I last saw h.er alive on April 3rd, 1929

and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Acute lymphoid leucaemia

Vincents angina

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Pulmonary edema

Lymphanites (duration) yrs. mos. 1 day ds.

18 Where was disease contracted if not at place of death? Towson Md

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? Blood test

(Signed) C. G. Warner, M. D.

, 19 (Address) Univ. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Prospect Hill — DATE OF BURIAL April 6 1929.

20 UNDERTAKER John Buma Sons — ADDRESS Towson Md

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44709

CERTIFICATE OF DEATH

88 E 44709

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS [redacted] REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frederick W. Schmidt

(a) RESIDENCE NO. 1823 E. Lafayette Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth C. Schmidt

6 DATE OF BIRTH (month, day, and year) July 25, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	5	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Jacob Henry Schmidt

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Aradt

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Records of
(Address) BALTIMORE CITY HOSPITALS

15 Filed 4-1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 26, 1929, to April 3, 1929, that I last saw him alive on April 3, 1929 and that death occurred, on the date stated above, at 4 A m.

THE CAUSE OF DEATH* was as follows:

Emphysema
Chronic Pneumonitis
Acute myocarditis
(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) John E. Moran, M. D.

19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	4/6 1929

20 UNDERTAKER Albert L. Hilt Jr. ADDRESS 1606 N. CHESTER

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 44710

31

1—PLACE OF DEATH

REGISTERED NO. E 44710

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1606 W. Mulberry ST. 19-27 WARD)

2—FULL NAME Fannie Logan

(a) RESIDENCE NO. 1606 W. Mulberry ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 11 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of: Benjamin Logan

6 DATE OF BIRTH (month, day, and year): Aug. 17, 1908

7 AGE: Years 20 | Months 8 | Days 15 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Georgetown S.C.

10 NAME OF FATHER: Henry Purvis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Florence S.C.

12 MAIDEN NAME OF MOTHER: Emma Hooks

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Kingstreet S.C.

14 Informant: Benjamin Logan

(Address): 1606 W. Mulberry St.

15 Filed APR 4 1929 THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 1, 1929

17 I HEREBY CERTIFY, That I attended deceased from Mar. 29, 19 29, to April 1, 19 29, that I last saw her alive on April 1, 19 29 and that death occurred, on the date stated above, at 11:25 p.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Probably Tubercular.

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical exam.

(Signed) Walter J. Jackson, M. D.

19 (Address) 1651 W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calary Cemtery

DATE OF BURIAL: 4/4 1929

20 UNDERTAKER: Walter B. Spriggs

ADDRESS: 139 W Hamburg St

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44711

CERTIFICATE OF DEATH.

31

E 44711

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 6 N. York St. Ward) 32-30

2-FULL NAME Ivy Lindsay.(C)

(a) RESIDENCE NO. 6 N. York St. **St.**_____ **Ward**_____

(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. 11 mos. 7 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married.

5a If married, widowed or divorced HUSBAND of (or) WIFE of Charles Lindsay.(C)

6 DATE OF BIRTH (month, day, and year) April 26, 1905.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	28	11.	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER William H. White. (C)

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Louise Ashton. (C)

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia.

14 Informant William White.(C) father.

(Address) 6 N. York St.

15 Filed APR 4 - 1929 HAMPSON JONES, M. D. Registrar

by

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2, 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs, ...mos. ....ds.

(Signed) (Coroner) M. D.

4/8, 1929 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dept. Calary Cemtry Date of Burial 4/4 1929

20 UNDERTAKER W. B. Spriggs ADDRESS 139 W. Hamburg St

very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44712

CERTIFICATE OF DEATH.

49 ✓

E 44712

1-PLACE OF DEATH

REGISTERED NO._____

City of BALTIMORE: (No. Church Home & Hosp. St., 28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Helen Polity

(a) RESIDENCE NO. 1401 Washington Blvd St. Ward E III

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 Color or Race W

5 Single, Married, Widowed, or Divorced. (write the word) widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Greece

PARENTS

10 NAME OF FATHER N. Polity

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Greece.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Greece.

14 Informant N. Polity

(Address) 1401 Washington Blvd.

15 Filed....., 19 THAMSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 4/2/29

17 I HEREBY CERTIFY, That I attended deceased from 3/6, 1929, to 4/2, 1929, that I last saw h alive on 4/2, 1929, and that death occurred, on the date stated above, at 7-20 p. m.

The CAUSE OF DEATH* was as follows:

General carcinomatosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) primary carcinoma of pancreas (duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Ronald A. Cox, M. D.

, 19 (Address) City.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wood Lawn County Date of Burial April 4 1929

20 UNDERTAKER George - & Ruth ADDRESS 1735 Harford ave

Very Important. See Instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 44713

Swish

HEALTH DEPARTMENT—CITY OF BALTIMORE

181-001

E 44713

CERTIFICATE OF DEATH.

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 627 N. Calvert St. 11-7 Ward)

2-FULL NAME Albert Smith

(a) RESIDENCE NO. 627 N. Calvert St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1895

7 AGE: 34 Years Months Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Md

(State or country)

PARENTS

10 NAME OF FATHER Andrew Smith

11 BIRTHPLACE OF FATHER (city or town): Md

(State or country)

12 MAIDEN NAME OF MOTHER Emma Zadler

13 BIRTHPLACE OF MOTHER (city or town): Md

(State or country)

14 Informant: Margaret Smith

(Address) 1712 Almond

15 Filed _____, 19 _____ HAMSON JONES M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apl. 3 29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Asphyxia due to Illuminating Gas Accidental

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary) _____

(duration) _____ yrs. _____ mos. _____ ds.

(Signed) _____ M. D. (Coroner)

Apl 4, 1929 (Address) 1659 Bremen

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Patrick Cemetery Date of Burial April 4 1929

20 UNDERTAKER: Geo. F. Ruth ADDRESS 1735 Harford

very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44714

E 44714.

161-001

CERTIFICATE OF DEATH.

REGISTRATION NO. 7147

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 416 N. Eden St. (Hospital) (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Carreri.

(a) RESIDENCE NO. 416 N. Eden ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE white

5 Single, Married, Widowed, or Divorced, (write the word) —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Apr 3-1929

7 AGE Years Months Days If LESS than 1 day, 12 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Salvatore Carreri

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Catherine Alacco

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Salvatore Carreri (Address) 416 N. Eden St

15 Filed APR 4 - 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 4 1929

17

I HEREBY CERTIFY, That I attended deceased from Apr 3, 1929, to Apr 4, 1929.

that I last saw her alive on Apr 4, 1929

and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Premature Child

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Obstruction

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Luigi D. Stefano M. D.

Apr 4, 1929 (Address) 1407 N. Exeter St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL 4/4 1929

UNDERTAKER Geo J Roth — ADDRESS 1725 Harford Ave

TION is very important See instructions on back of certificates.

...TION OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-

...ATH should be stated EXACTLY. PHYSICIANS should state

Spec.—12-9-25—A Co.—200 Bks.

Rettaliata

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44715
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

E 44715
REGISTERED NO.

City of BALTIMORE: (No. 404 Forrest- St. 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vincent John amarino

(a) RESIDENCE NO. 404 Forrest. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) aug 24-1928

7 AGE: Years | Months 7 | Days 9 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Balto., md.

(State or country)

PARENTS

10 NAME OF FATHER Carmelo amarino

11 BIRTHPLACE OF FATHER (city or town) Balto

(State or country)

12 MAIDEN NAME OF MOTHER Emma Lo Monaco

13 BIRTHPLACE OF MOTHER (city or town) Italy

(State or country)

14 Informant Carmelo amarino

(Address) 404 Forrest. St

15 Filed 1929 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4- 3 1929

17 I HEREBY CERTIFY, That I attended deceased from March 20 1929, to Apr 3, 1929, that I last saw him alive on Apr 3, 1929, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Acute Bastritis

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? — Date of .....

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Antony L. Rettaliata, M. D.

April 3, 1929 (Address) 1038 E Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery Date of Burial 4/4 1929

UNDERTAKER: Geo. J. Ruth ADDRESS: 1735 Harford ave

Very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44716 — **CERTIFICATE OF DEATH** — 14-001 — **E 44716**

1—PLACE OF DEATH 1705 Druid Hill Avenue — REGISTERED NO. 14-20

CITY OF BALTIMORE: (No. ..... ST. or WARD) ..... (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harry H. Johnson

(a) RESIDENCE NO. 1705 Druid Hill Ave ST., ... WARD
(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Fannie Johnson

6 DATE OF BIRTH (month, day, and year) 2-18-1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63	1	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chiropodist

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

10 NAME OF FATHER Walter Johnson

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Maryland

12 MAIDEN NAME OF MOTHER Catherine Dever

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Fannie Johnson (Address) 1705 Druid Hill Ave.

15 Filed APR 4 - 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1st 1929

17 I HEREBY CERTIFY, That I attended deceased from 3-28-29, 19..., to 4-1-29, 19..., that I last saw he[illegible] alive on 4-1-29, 19..., and that death occurred, on the date stated above, at 2:15 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Right Hemiplegia

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) W. B. Butler, M. D.

, 19 (Address) 425 N. Carlin Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Apr. 4 1929
UNDERTAKER: W. R. A. Elliott	ADDRESS: 1725 Eastland Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44717

CERTIFICATE OF DEATH

E 44717

1—PLACE OF DEATH

REGISTERED NO. 74

CITY OF BALTIMORE: (No. St. Joseph's Hosp. ST., 3-5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Nicholas V. McGann

(a) RESIDENCE NO. 242 Allendale St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred lifetime yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb 13-1867

7 AGE: Years 62 | Months 1 | Days 20 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Policeman. 061

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: John McGann

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Bridget Cunningham

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Terrance McGann

(Address) 242 Allendale St

15 Filed APR 4 - 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/2/29

17 I HEREBY CERTIFY, That I attended deceased from 4/1/29, 19, to 4/2/29, 19,

that I last saw him alive on 4/1/29, 19

and that death occurred, on the date stated above, at 4 P.M. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical.

(Signed) Irving C. Peters, M. D.

, 19 (Address) St Joseph's Hosp

*State the Disease Causing Death, or In deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: 4/5 1929

UNDERTAKER: Chas. F. Braun & Son

ADDRESS: 118 W. Mt. Royal Ave

Spec.—1-12-23—M&T—500 Blks.

E 44718

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44718

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 3029 St. Paul ST. 17-50 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Agnes Mary McManus

(a) RESIDENCE No. 3029 St. Paul ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 26-1851

7 AGE: Years 78 Months 2 Days 8 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Felix McManus

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Julia Schultz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Penna

14 Informant: Mrs Julia G. Helfrich

(Address) 3029 St. Paul St

Filed PR 4 - 1929

Per

HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 3rd 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1929, to April 3, 1929, that I last saw her alive on April 2, 1929 and that death occurred, on the date stated above, at 10 m

The CAUSE OF DEATH* was as follows:

Generalized Atherosclerosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. R. Goodwin, M. D.

, 19 (Address) 2923 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: 4/6 19 29

UNDERTAKER: Chas F. Maus & Son

ADDRESS: 118 W Mt Royal Ave

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44719

4719 Accident occured

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Mt Olivet Lane & Balto Sts

City of BALTIMORE: (No. St. Agnes Hospital, St., 17th Ward)

2-FULL NAME Philip Woodland

(a) RESIDENCE NO. 523 Brewer St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sophie Woodland

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	58	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Sophie Woodland

(Address) 523 Brewer

Filed 19 HAMPSON JONES, M. D.

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/1 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental -

Burns caused in an explosion Shrapnel & internal injuries (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas H Brooks M. D.

(Coroner) Deputy

4/4, 1929 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the state yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem Date of Burial 4-6 1929

20 UNDERTAKER Daniel Coates ADDRESS Oaks 4/6

R4 1929

Very Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44720

CERTIFICATE OF DEATH

100-001

E 44720

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1515 E. Biddle ST. 8-13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank B. Norris

(a) RESIDENCE NO. 1515 E. Biddle ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elva L. Norris

6 DATE OF BIRTH (month, day, and year) May 16 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	11	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Paper Hanger

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penna

PARENTS

10 NAME OF FATHER Reese S. Norris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Sylvia Wright

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Elva L. Norris

(Address) 1515 E. Biddle St

15 Filed APR 4 1929 T. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3 1929

17 I HEREBY CERTIFY, That I attended deceased from Mar. 26 -, 1929, to April 3 -, 1929, that I last saw him alive on April 2 -, 1929 and that death occurred, on the date stated above, at 145 a m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) — yrs. — mos. 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edwin B. Fenby, M. D.

4/3/1929 Address 1223 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	April 6 1929
20 UNDERTAKER	ADDRESS
George W. Zubler	737 E. Eager St

Spec.—2-29-28—L. F. S.—500 Bks.

E 44721

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129

E 44721

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St. No-37 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Schaefe

(a) RESIDENCE NO. 3929 Fernwood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Johanna Schaefe

6 DATE OF BIRTH (month, day, and year) Jan 22-1871

7 AGE	Years	Months	Days 11	If LESS than 1 day, ...hrs. or ....min.
	58	2	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Otto Schaefe

(Address) 3929 Hudson St.

15 Filed APR 4 - 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3 1929

17 I HEREBY CERTIFY, That I attended deceased from March 12, 1929 to April 3, 1929

that I last saw h... alive on April 3, 1929

and that death occurred, on the date stated above, at 10 30 A m.

The CAUSE OF DEATH* was as follows:

Hypertensive Cardio vascular renal disease, Cardiac hypertrophy dilatation, heart failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Intestinal hemorrhage

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Wm H. Varney, M. D.

. 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oaklawn Cemetery

DATE OF BURIAL Apr. 7 1929

20 UNDERTAKER George W. Zirkler

ADDRESS 1737 E. Eager St

Cor.—12-9-25—A Co.—200 Bks.

E 44722

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

186-001

E 44722

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) Mercy Hosp St. 1637 Ward

2-FULL NAME John Rau

(a) RESIDENCE NO. 1114 S Conkling St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced. (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elizabeth Rau

6 DATE OF BIRTH (month, day, and year): Oct. 17-1848

7 AGE: Years 80 Months 5 Days 17 IF LESS than 1 day.....hrs. or.....min. 16.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Germany

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town):

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town):

(State or country)

14 Informant Son

(Address) 1114 S. Conkling St.

15 Filed Dec 4 19 29 C. HAMPSON JONES, M. D. Registrar

R 4 - 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Dec 3-9 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

I-a. Immediate - Fract. Base of Skull.

Accidentally Struck by B. R. R. Engine

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Alcoholism

(duration) yrs. mos. ds.

(Signed) W. J. Reilly M. D.

Dec 4 , 19 29 (Coroner) (Address) 1659 Reisterstown Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery Date of Burial: Apr 6 1929

20 UNDERTAKER: George M. Zickler ADDRESS: 1737 E. Eager St

Very Important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 44723

ZACHAR

HEALTH DEPARTMENT—CITY OF BALTIMORE

97-902

E 44723

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No. 15-56 ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Zachar

(a) RESIDENCE No. 2421 Shirley Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rae Zachar

6 DATE OF BIRTH (month, day, and year) Nov. 25. 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29	4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Brooklyn, N. Y.

PARENTS

10 NAME OF FATHER Zachary Joseph Zachar

11 BIRTHPLACE OF FATHER (city or town) (State or country) Galicia, Russian

12 MAIDEN NAME OF MOTHER Emma Witcover

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Marion, S. Carolina

14 Informant J. Lewis

(Address) 1439 E Balto. St

15 Filed 4-1929 HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/3 1929

17 I HEREBY CERTIFY, That I attended deceased from 4/2/ 1929 to 4/3/ 1929

that I last saw h[illegible] alive on 4/3/ 1929

and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonitis c a complicating meningitis

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? Yes Date of 4/2/29

Was there an autopsy? Yes partial

What test confirmed diagnosis? autopsy

(Signed) B. J. Cohen, M. D.

, 19 (Address) Sinai Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sinai Rosedale — DATE OF BURIAL 4-4- 1929

20 UNDERTAKER Jack Lewis, 1439 E Balto St — ADDRESS

Spec.—I-10-21—M&T—1500 Bks.

E 44724

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44724

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 617 University Pkwy ST. 17-49 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Virginia Jenkins Hains,

(a) RESIDENCE No. 617 University Pkwy ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Maj. Genl. Peter C. Hains, U.S.A.

6 DATE OF BIRTH (month, day, and year): May 5, 1840

7 AGE: Years 88 Months 10 Days 29 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Baltimor, Md.

PARENTS

10 NAME OF FATHER: Adml. T.A. Jenkins U.S.N.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Orange County Va.

12 MAIDEN NAME OF MOTHER: Anne Power

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: (Son) Col. John P. Hains U.S.A.

(Address) 617 University Pkwy ~~Baltimore Md~~

15 Filed APR 4 1929 HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 4th 1929.

17

I HEREBY CERTIFY, That I attended deceased from Several times to in 1928-9

that I last saw her alive on or about Jan. 1929 and that death occurred, on the date stated above, at 1/15 m.

The CAUSE OF DEATH* was as follows:

Sudden cessation of Heart Action from advanced Senility.

(duration) many yrs. mos ds.

CONTRIBUTORY (Secondary) Senility many yrs.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No. Date of

Was there an autopsy? View of remains.

What test confirmed diagnosis?

(Signed) J. M. Hartwell, M. D.

, 19 (Address) Colonel U.S. Army. Baltimore Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: U.S. National Cemetery Arlington, Va.

DATE OF BURIAL: April 6th 1929

20 UNDERTAKER: Henry W. Jenkins Sons Co

ADDRESS: Orchard & McCulloh

FOR A very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 44725 HEALTH DEPARTMENT—CITY OF BALTIMORE E 44725

CERTIFICATE OF DEATH. X 100 children & sick people restored child.

1-PLACE OF DEATH Provident Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 1514 Division ST. Pennsylvania WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Robinson (Henry Miles)

(a) RESIDENCE No. 1619 Madison ST., WARD Niagara
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant

6 DATE OF BIRTH (month, day, and year): Sept. 16-28

7 AGE — Years: — Months: 6 Days: 19 If LESS than 1 day, hrs. or min: 16

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Newportnews Va.

PARENTS

10 NAME OF FATHER: Will Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Pauline Timmons

13 BIRTHPLACE OF MOTHER (city or town) (State or country): S.C.

14 Informant: Mother Pauline Robinson
(Address): 1619 Madison Ave

15 Filed APR 4 - 1929 HAMILTON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr. 2 19 29

17 I HEREBY CERTIFY, That I attended deceased from March 30, 19 29, to Apr. 2, 19 29, that I last saw h/ alive on Apr 2, 19 29, and that death occurred, on the date stated above, at 10 25 m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia
Primary

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Rickets

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? undetermined

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) C. Robinson, M.D.

4/6, 19 29 (Address) 1000 Arlington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: 4/7/ 19 29

20 UNDERTAKER: Chas. H. Holland — ADDRESS: 1631 Druid Hill Ave

Cor.—10-10-29—A Co.—100 Bks.

E 44726

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 44726

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 618 W. Mulberry St. 17-25 Ward) 24-001

2-FULL NAME Walter Mackerl

(a) RESIDENCE NO. 618 W. Mulberry St., Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ½ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Negro

5 Single, Married, Widowed or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE: Years 53 | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Odd
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Unknown

14 Informant Maggie Wilson
(Address) 618 W Mulberry St

1929 C. HAMPSON JONES, M. D., Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) Eugene Zeller, M. D.

4/2. 1929 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery — DATE OF BURIAL: April 4 1929

20 UNDERTAKER: Ernest Pree — ADDRESS: 1140 W Hamilton St

Important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44727

CERTIFICATE OF DEATH.

182 E 44727

1-PLACE OF DEATH Found floating in the water at

City of BALTIMORE: (No. William & York Sts. St. 12-6 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Unknown. (C) Moses Wilson C

(a) RESIDENCE NO. Do not know. 719 S. Charles St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 2 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	~~Married~~ Do not know.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ~~Lucy Wilson C~~ Do not know.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	35	----------		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer Do not know.

(b) General nature of industry, business, or establishment in which employed (or employer) 87

(c) Name of employer

9 BIRTHPLACE (city or town) South Carolina

(State or country) Do not know.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Do not know.

14 Informant Police Report. (Address) [illegible] S. D.

Filed APR 4 1929 C. HAMPSON JONES, M. D. Registrar

very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Body found March 29, 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Drowning death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning.
Probably accidental

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.
(Coroner)

4/2, 1929 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY. Date of Burial 19

20 UNDERTAKER Commissioner Health ADDRESS APR 4 - 1929

Cor.—12-9-25—A Co.—200 Bks.

E 44728 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

182

E 44728 REGISTERED NO.

1-PLACE OF DEATH Found floating in the water at

City of BALTIMORE: (No. Foot of Woodall St. St., 24-35 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Unknown. (C)

(a) RESIDENCE NO. Do not know. St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Do not know.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Do not know.

6 DATE OF BIRTH (month, day, and year): Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	40	----------		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Do not know.

(b) General nature of industry, business, or establishment in which employed (or employer): 087

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Do not know.

PARENTS

10 NAME OF FATHER: Do not know.

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Do not know.

12 MAIDEN NAME OF MOTHER: Do not know.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Do not know.

14 Informant: Police Report. S.D.

(Address)

15 Filed ....., 1925 C. HAMPSON JONES, M. D. Registrar

Per .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Body found March 27, 1925 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning.

Probably accidental.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

(Coroner)

4/2, 1925 (Address) 107 E. Chase St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: PUBLIC CEMETERY. Date of Burial 19

UNDERTAKER

ADDRESS

Commissioner Health.

APR 4 1925

very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44729 — CERTIFICATE OF DEATH — 90 ✓ E 44729

1—PLACE OF DEATH — REGISTERED NO. 16-22

CITY OF BALTIMORE: (No. 708 N. Monroe ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William T. Frederick

(a) RESIDENCE NO. 708 N. Monroe ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Almira C. Frederick

6 DATE OF BIRTH (month, day, and year) October 6, 184[illegible]

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
83	5	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas Frederick

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER (Unknown) Freeburger

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mr. George W. Wickum

(Address) 2940 Harford Road

PR4 - 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 1, 1929

17 I HEREBY CERTIFY, That I attended deceased from January 5th, 1929, to April 1, 1929, that I last saw him alive on April 1, 1929 and that death occurred, on the date stated above, at 11.15 P. m.

The CAUSE OF DEATH* was as follows: Pyelo-Nephritis. Myocarditis.

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Frank V. Dees, M. D.

4/3, 1929 (Address) 2636 Edmondson Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL April 6 1929

UNDERTAKER Russell Cook

ADDRESS 1503 West Baltimore St

Spec.—1-10-21—M&T—1500 Bks.

E 44730

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44730

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Franklin Square Hospital

CITY OF BALTIMORE: (NO. Blanche Ridgely ST. 2716 WARD)

2-FULL NAME Mrs. Blanche Temple

(a) RESIDENCE NO. 2716 Fairmount Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wilmer L. Temple

6 DATE OF BIRTH (month, day, and year): June 3, 1887

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
41	10	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: At Home

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland

PARENTS

10 NAME OF FATHER: Charles Chandler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ellicott City, Maryland

12 MAIDEN NAME OF MOTHER: Clara Hoffman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore, Maryland

14 Informant: Mr. Wilmer L. Temple

(Address) 2716 W. Fairmount Ave.

15 Filed 1929 HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-3 1929

17 I HEREBY CERTIFY, That I attended deceased from 3-20, 1929, to 4-3, 1929, that I last saw her alive on 4-3, 1929, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Chronic appendicitis

Chronic Cholecystitis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral embolism

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 4-2-29

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. W. Peake, M. D.

4/3, 19 29 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cemetery

DATE OF BURIAL: April 6 19 29

20 UNDERTAKER: J. A. Block

ADDRESS: 1003 West Baltimore St.

Spec.—2-29-28—L. F. S.—500 Bks.

E 44731

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 44731

1—PLACE OF DEATH

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 211 S. Mount ST., 14-28 WARD)

2—FULL NAME Harriett Ann Slingerland

(a) RESIDENCE NO. 211 S. Mount ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John H. Slingerland

6 DATE OF BIRTH (month, day, and year) March 16, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76	-	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Clarksburg, Montgomery
(State or country) County, Maryland

PARENTS

10 NAME OF FATHER James A. Crandell

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary Hamilton

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Mrs. J. T. Gibson
(Address) 211 S. Mount St.

15 Filed Apr 4 1929 19 H. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3, 1929

17 I HEREBY CERTIFY, That I attended deceased from February 1st, 1929, to April 3rd, 1929, that I last saw her alive on April 2nd, 1929 and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. D. Lybrand, M. D.

4.3. 1929 (Address) 211 W. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Apr. 6 1929
20 UNDERTAKER Robert D. Cook	ADDRESS 1003 West Baltimore St

Cor.—10-10-29—A Co.—100 Bks. Antonio Belvelacqua

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44732

CERTIFICATE OF DEATH

E 44732

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 246 Exeter St., 35 Ward) 1929

2-FULL NAME Antonio Belvelacqua

(a) RESIDENCE NO. 246 Exeter St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosa Landino

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	41			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) do
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Italy

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Italy

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Italy

14 Informant Rosa Landino
(Address) 246 E Exeter St

Filed APR 4 1929 HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 30 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:
Homicide
Gunshot Wound Head.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Shock
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 246 E Exeter.
Did an operation precede death? — Date of
Was there an autopsy? Yes
What test confirmed diagnosis?
(Signed) G C Clodes, M. D.
19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	4-4 1929
20 UNDERTAKER	ADDRESS
George J Ruth	1735 Hanford Ave

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44733

CERTIFICATE OF DEATH

185 E 44733

1-PLACE OF DEATH

City of Baltimore: (No. 147 N. Linwood Ave St. 6-11 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary A. Birthistle

(a) RESIDENCE NO. 147 Linwood Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Wm. B. Birthistle

6 DATE OF BIRTH (month, day, and year) Oct. 7/69

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	59	5	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Silas C. Hall

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Winifred Flemming

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Dublin, Ireland

14 Informant Winifred Birthistle
(Address) 147 N. Linwood Ave

15 Filed C. HAMPSON JONES, M. D. Registrar

R4 - 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 1/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Failure - Mitral Insuff.
Accidently fell down stairs in Res.
Mar 19/29. Fracture 7th rib (rt) &
Probable [illegible] (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Surgery & Examination

(Signed) J. Hooker M. D.

(Address) 505 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL April 5 1929

20 UNDERTAKER Frank V. Lepitow

ADDRESS 2818 E. Baltimore

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44734

CERTIFICATE OF DEATH

E 44734

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1111 N. Bond St. 8-13 Ward)

2-FULL NAME Catherine Benney

(a) RESIDENCE NO. 1111 N. Bond St St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 4/1919

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	9	5	29 18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Norman Benney

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Breuning

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto., Md.

14 Informant Norman Benny
(Address) 1111 N. Bond St

15 Filed R4 - 1929 C. HAMILTON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 2/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Epilepsy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Autopsy

(Signed) J. C. Bauer, M. D.

4/3/29 19 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ft Matthews Cemetery	Apr 5 1929
20 UNDERTAKER	ADDRESS
H Henry Lutz	1203 N Broadway

Important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44735

CERTIFICATE OF DEATH.

90 E 44735

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 117 W. Barre St. St. 22-30 Ward)

2-FULL NAME John Corrody.

(a) RESIDENCE NO. 117 W. Barre St. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Do not know.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	70	----------		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of Indnstry, business, or establishment in which employed (or employer) Odd Jobs

(c) Name of employer

9 BIRTHPLACE (city or town)_____

(State or country) Do not know.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) Do not know.

14 Informant Rose Landley.

(Address) 117 W. Barre St.

15 Filed 4 1929 C. HAMPSON JONES, M. D. Registrar

Per Asst

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 31, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the Heart.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) [signature] M. D.

(Coroner)

4/4, 1929 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Date of Burial 4-4 1929

UNDERTAKER E & B Slade ADDRESS 115 E. West St.

very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 44736 HEALTH DEPARTMENT—CITY OF BALTIMORE E 44736

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 801 Wellington ST. V 13 C 27 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Arnuiger (premature)

(a) RESIDENCE NO. 801 Wellington ST., WARD 13

(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Dead | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 4-1-29

7 AGE — Years | Months | Days | If LESS than 1 day hrs. or min.: 14

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) 801 Wellington St

PARENTS

10 NAME OF FATHER Elmer Arnuiger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mildred Dorsey 4-2-29

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mrs Mildred Arnuiger

(Address) 801 Wellington St

15 - 1929

C. HAMPSON JONES, M. D., Registrar.

Per [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-1 1929

17 I HEREBY CERTIFY, That I attended deceased from 4-1 1929 to 4-2 1929

that I last saw him alive on 4-1 1929

and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Premature gestation

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical exam.

(Signed) C. A. Culpepper M. D.

(Address) 3201 Woodland Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health.

ADDRESS APR 4 - 1929

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 44737 HEALTH DEPARTMENT—CITY OF BALTIMORE E 44737

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 161

CITY OF BALTIMORE: No. 2835 W. North Ave ST. 15-68 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Not named Maddox

(a) RESIDENCE. No. 2835 W. North Ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 30 minutes ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of No

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	~~Days~~	If LESS than 1 day hrs. or 30 min.
	—	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. md

PARENTS

10 NAME OF FATHER Charles Edward Maddox

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md —

12 MAIDEN NAME OF MOTHER Martha Walthasina Barry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant
(Address)

15 Filed 4-1929, 19 C. HAMPSON JONES, M. D. Registrar

Reg. 140 RKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/3 1929

17 I HEREBY CERTIFY, That I attended deceased from 4/3, 1929, to 4/3, 1929, that I last saw h[illegible] alive on 4/3, 1929, and that death occurred, on the date stated above, at 1015 m.

The CAUSE OF DEATH* was as follows:

Premature birth. 5th month

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Atelectasis 30 minutes

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Visual Exam

(Signed) Hamburger, M. D.

4/3, 1929 (Address) 3217 Eastwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health.

ADDRESS APR 4 - 192

Per Wm E WOODALL

Spec.—2-29-28—L. F. S.—500 Bks.

223913
E 44738

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

161-09
E 44738

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 96-40 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Schleifer

(a) RESIDENCE NO. 3130 Kenyon ST., Care WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word):

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years | Months | Days: 1 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md—

10 NAME OF FATHER: Herman —

11 BIRTHPLACE OF FATHER (city or town) (State or country):

12 MAIDEN NAME OF MOTHER: Mitchell

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Friends—

(Address) JOHNS HOPKINS HOSPITAL

15 Filed APR 4 1929, C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 31-29

17 I HEREBY CERTIFY, That I attended deceased from March 31, 1929, to March 31, 1929, that I last saw her alive on March 31, 1929 and that death occurred, on the date stated above, at 7 5-0 P m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) J. C. Goodwin, M. D.

4/3/, 1929 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: D. JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: 19

20 UNDERTAKER: Commissioner Health

ADDRESS APR 4 1929

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44739

CERTIFICATE OF DEATH.

E 44739

REGISTERED NO. 161-08

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1722 SI. 7-13 WARD)

2-FULL NAME Daisy Bagley

(a) RESIDENCE No. 1722 Oakland Ave. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Black

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 27, 1929

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John Bagley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mabel Butts

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Wm. H. Gutschow

(Address) Johns Hopkins Hospital

15 Filed 4-1929 C. HAMPSON JONES, M. D. Registrar

Per 2151 AKP

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 27 1929

17

I HEREBY CERTIFY, That I attended deceased from 3-27, 1929, to 3-27, 1929

that I last saw alive on 3-27, 1929

and that death occurred, on the date stated above, at 7.00 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. H. Gutschow M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

JOHNS HOPKINS HOSPITAL

Commissioner Health

APR 4 - 1929

Per. Wm. E. McGrath

FROM IS very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44740 E 44740

CERTIFICATE OF DEATH.

REGISTERED NO. 161

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) ST., 6-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Bryant

(a) RESIDENCE NO. 406 E. Broadway ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar. 20, 1929

7 AGE Years Months Days 1 1/2 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER James Bryant

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Irma Krauser

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Gaither

(Address) Johns Hopkins Hospital.

15 Filed 4-1-1929 G. HAMPSON JONES, M. D. Registrar

BY

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar. 31 1929

17 I HEREBY CERTIFY, That I attended deceased from 3-20, 1929 to 3-31, 1929

that I last saw her alive on 3-31, 1929

and that death occurred, on the date stated above, at 8.30 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Mrs. Gaither M. D.

19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

JOHNS HOPKINS HOSPITAL

Commissioner Health.

APR 1 1929

PRINT in very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 44741

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 44741

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST. ..... WARD)

2—FULL NAME Edward Stansbury

(a) RESIDENCE NO. 1157 Mount ST. ..... WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~: Susie Stansbury

6 DATE OF BIRTH (month, day, and year): 1890

7 AGE: Years 39 | Months | Days | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: James Stansbury

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Co

12 MAIDEN NAME OF MOTHER: Annie Watts

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Mrs. Stansbury

(Address): 1157 N Mount St

15 Filed 4-1929 By ... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-1-29

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1929, to April 1, 1929, that I last saw him alive on April 1st, 1929 and that death occurred, on the date stated above, at 4.15 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary T.B.

Intercostal Neuralgia

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes Path. Lab. Clinical

What test confirmed diagnosis

(Signed) Henry Smith, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: April 3 1929

20 UNDERTAKER: Hanna E. Wright — ADDRESS: 1360 Mc Cam

Spec.—1-12-23—M&T—500 Blks.

E 44742

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44742

CERTIFICATE OF DEATH.

31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1139 N Carey ST. 16-2 WARD)

2-FULL NAME Helen Sarafi

(a) RESIDENCE NO. 1139 N Carey ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 1911

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
17	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work school girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Robert Sarafi

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Elyra Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs Elizabeth Sarafi

(Address) 1139 N Carey St

15 Filed 4 - 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April-2 1929

17 I HEREBY CERTIFY, That I attended deceased from March (—), 1929, to April-2, 1929, that I last saw h[illegible] alive on April 2 —, 1929, and that death occurred, on the date stated above, at 10:40 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) W. J. Columbus M. D.

4-2 1929 (Address) 2039 McCulloh

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pt Lookout Md	19
20 UNDERTAKER	ADDRESS
Thomas E Wright	864 N Carey

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44743
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

90 E 44743

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of BALTIMORE: (No. 715 N. Collington Ave. Ward 10)

2-FULL NAME Louisa N. Burkhard

(a) RESIDENCE NO. 715 N. Collington Ave. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Melchior C. Burkhard

6 DATE OF BIRTH (month, day, and year) Jan 25 1845

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	84	9	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Charlotte

(State or country) Va

PARENTS

10 NAME OF FATHER David C. Gillette

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Miranda Burke

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Mrs. Annie B. Austin

(Address) 715 N. Collington Ave

15 Filed 4-1929 C. HAMPSON JONES, M. D. Registrar

Per

very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 3 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

(Signed) J. H. Bowen M. D.

(Coroner)

4/4/29 (Address) 508 E. North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery Date of Burial Mar 19 29

20 UNDERTAKER Wm J. Lechner. Inc ADDRESS 1-29 Cit

Spec.—2-29-28—L. F. S.—500 Blks.

E 44744

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 44744

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 601 E. 38th. ST., 9-47 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ada M. Stansbury

(a) RESIDENCE NO. 601 E. 38th. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles F. Stansbury

6 DATE OF BIRTH (month, day, and year) July 29-1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45	8	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 0?

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Co. Md.
(State or country)

PARENTS

10 NAME OF FATHER James T. Denny

11 BIRTHPLACE OF FATHER (city or town) Maryland
(State or country)

12 MAIDEN NAME OF MOTHER Martha Durham

13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)

14 Informant Charles F. Stansbury

(Address) 601 E. 38th. St.

15 Filed 4-1929 C. HAMPSON JONES, M. D. Registrar

By RAH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2-1929

17 I HEREBY CERTIFY, That I attended deceased from May 6 th, 1928, to April 2, 1929, that I last saw h[illegible] alive on April 2, 1929 and that death occurred, on the date stated above, at 4.50 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 11 mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Symptoms

(Signed) Edw. H. Benson, M. D.

4/3, 1929 (Address) Overlea Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood	April 5 1929.
20 UNDERTAKER Horace F. Burgee	ADDRESS 363 Falls Road

Spec.—2-29-28—L. F. S.—500 Bks.

E 44745

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

16 V E 44745

1—PLACE OF DEATH

REGISTERED NO. .....

CITY OF BALTIMORE: (No. 1528 Tolling ST. 19-28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Young

(a) RESIDENCE NO. 1528 Tolling ST., ... WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Infant

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 4 1929

7 AGE — Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Henry J. Young

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Marie Tindel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Henry J. Young

(Address) 1528 Tolling St

15 Filed ..... 19 C. HAMPSON JONES, M. D. Registrar

4-1-1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4-1929

17 I HEREBY CERTIFY, That I attended deceased from ..... 19 ..., to April 4 19 29, that I last saw h[illegible] dead alive on April 4 19 29 and that death occurred, on the date stated above, at 9:45 A. m.

The CAUSE OF DEATH* was as follows:

Congenital atelectasis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease enntracted if not at place of death?

Did an operation preeede death? no Date of

Was there an autopsy? no

What test ennfirmed diagnosis? clinical findings

(Signed) A. V. Bruchez, M. D.

4/1 19 29 (Address) 31 S. Strieker St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature nf Injury, and (2) whether Aecidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet — DATE OF BURIAL April 5/29 19

20 UNDERTAKER Harry N. Wittke, 1531 N. Lombard — ADDRESS

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE E 44746

E 44746

CERTIFICATE OF DEATH.

× 31

1-PLACE OF DEATH United States Marine Hospital,

CITY OF BALTIMORE: (No.) Baltimore, Maryland. (ST.) 12-51 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Fluhart

(a) RESIDENCE No. Gas Sloop "Virginia" ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs 8 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

Crisfield Md

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Laura F. Fluhart

6 DATE OF BIRTH (month, day, and year) Mar. 15, 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80		17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) Seaman

(c) Name of employer Gas Sloop "Virginia"

9 BIRTHPLACE (city or town) Somerset County (State or country) Maryland

PARENTS

10 NAME OF FATHER Levin Fluhart

11 BIRTHPLACE OF FATHER (city or town) Accomac Co. (State or country) Virginia

12 MAIDEN NAME OF MOTHER Sally Tyler

13 BIRTHPLACE OF MOTHER (city or town) Somerset Co. (State or country) Maryland

14 Informant U. S. Marine Hospital (Address)

15 C. HAMPSON JONES, M. D. Registrar

1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2 1929

17

I HEREBY CERTIFY, That I attended deceased from December 1 1928 to April 2 1929, that I last saw him alive on April 2 1929, and that death occurred, on the date stated above, at 9;30 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis, pulmonary

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical examination and laboratory findings.

(Signed) Ralph L. Porter M. D.

, 19 (Address) U. S. Marine Hospital Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's Cemetery

DATE OF BURIAL April 5, 1929

20 UNDERTAKER E. LeRoy Stiffler

ADDRESS 125 E. North Ave

Spec.—1-10-21—M&T—1500 Bks.

E 44747

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44747

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH Woman's Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (NO. 17-51 ST. WARD)

2-FULL NAME Minnie Anna Miller

(a) RESIDENCE NO. 2726 Oak St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 13 yrs. 4 mos. 15 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thompson Dayaid Miller

6 DATE OF BIRTH (month, day, and year) Aug 10-1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
37	37	8	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work N. W. 037

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Dorchester Co (State or country) md.

PARENTS

10 NAME OF FATHER Peter Cook

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Hutchinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dorchester Co — md.

14 Informant Oakland

(Address) 2726 Oak St.

15 Filed 4-1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4 1929

17 I HEREBY CERTIFY, That I attended deceased from March 12, 1929, to April 4, 1929, that I last saw her alive on April 4, 1929, and that death occurred, on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Primary carcinoma of vulva with abdominal and pulmonary metastasis (duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) metastases (duration) — yrs. — mos. — ds.

18 Where was disease contracted, if not at place of death? —

Did an operation precede death? yes Date of 3-15-29

Was there an autopsy? no

What test confirmed diagnosis? Laboratory

(Signed) Carle P. Clemson, M. D.

, 19 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hereford, Md

DATE OF BURIAL April 6, 1929

20 UNDERTAKER E. LeRoy Stiffler

ADDRESS 125 E North Ave

FROM is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44748

CERTIFICATE OF DEATH

55 E 44748

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Mercy Hospital St. 7-12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Burns

(a) RESIDENCE NO. 2400 E. Monument St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 24 – 1884

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	44	8	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.

(State or country) Md

PARENTS

10 NAME OF FATHER John Burns

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Ireland.

12 MAIDEN NAME OF MOTHER Margery Kirby

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md.

(State or country)

14 Informant Mrs Willia Wallace

(Address) 3700 Edmund Rd.

15 Filed 4 - 1929 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/3/29 19

17 I HEREBY CERTIFY, That I attended deceased from 3/23/29, 19..., to 4/3/29, 19...,

that I last saw him alive on 4/3/29, 19...,

and that death occurred, on the date stated above, at 10 55 PM. m.

The CAUSE OF DEATH* was as follows:

Osteomyelitis Lower Jaw

(duration) ... yrs. ... mos. 14 ds.

CONTRIBUTORY (Secondary) Pulmonary Infarction

(duration) ... yrs. ... mos. 4 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Yes Date of 3/28/29

Was there an autopsy?

What test confirmed diagnosis? X-ray

(Signed) J. S. Whitehead, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
New Cathedral Cemetery	Apr 8 1929
20 UNDERTAKER	ADDRESS
Wm C Fuller & Son	2334 Gilmor St

very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44749

CERTIFICATE OF DEATH

× 90 E 44749

1—PLACE OF DEATH

REGISTERED NO. 12-44

CITY OF BALTIMORE: (No. Union Memorial Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mr. Richard Baldwin

(a) RESIDENCE NO. Waterbury Anne Arundel Co. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Gertrude Baldwin.

6 DATE OF BIRTH (month, day, and year) Sept 18, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	6.	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Civil Engineer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Co. Co. Co Maryland

10 NAME OF FATHER Richard Baldwin

11 BIRTHPLACE OF FATHER (city or town) (State or country) U. S. Co Maryland

12 MAIDEN NAME OF MOTHER Jeanne Turbey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va.

14 Informant Gertrude Baldwin

(Address) Waterbury Co. Co. Md

15 Filed 5-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3rd 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 25th, 1929, to April 3rd, 1929, that I last saw him alive on April 3rd, 1929 and that death occurred, on the date stated above, at 11:20 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis heart decompensation
& Renal involvement

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Uremia, Myocardial failure 5 (?)
Edema, ascites (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Galmer F. C. Williams M. D.

4/3. 1929 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baldwin Church Yard Millersville Md	April 5th 1929
20 UNDERTAKER	ADDRESS
Henry Heukins & Sons Co	Edmondson Ave & Bentalou St

Cor.—10-10-29—A Co.—100 Bks.

Toney.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44750

CERTIFICATE OF DEATH

9 0

E 44750

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2029 Maisel St. 25-72 Ward)

2-FULL NAME Clinton M Toney

(a) RESIDENCE NO. 2029 Maisel St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, ~~Married, Widowed~~ or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Apr 27 77

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	51	11	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Painter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Baltimore

PARENTS

10 NAME OF FATHER Louis H Toney

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto.

12 MAIDEN NAME OF MOTHER Rosa McGlaughlin

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Miss Lottie Toney
(Address) 2219 Brenner Av.

15 Filed 1929 Robt. Jones M. D. Registrar

MAY 5 - 1929 HAMPSON JONES

By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-3-1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to L death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas V Grove M. D.

4/3, 1929 (Address) Coroner. S. Ed. Dr. Brooklyn Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Parks Cemetery	Apr. 5, 1929
20 UNDERTAKER	ADDRESS
John C. Mitchell & Sons	1900 Eutaw Pl.

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

44751

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44751

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of Baltimore: (No. 413 N Mount St., 14-27 Ward)

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Susannah Brown

(a) RESIDENCE NO. 413 N Mount St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced (or) WIFE of Joseph Brown

6 DATE OF BIRTH (month, day, and year) Jan 1892

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	37			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work at Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Andrew Jackson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) md

12 MAIDEN NAME OF MOTHER Mary Howard

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) md

14 Informant Joseph Brown
(Address) 413 N. Mount St

Filed APR 5 - 1929 C. HAMPSON JONES M.D. Registrar
By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) C & Lawsonia

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? 413 N Mount

Did an operation precede death? — Date of —

Was there an autopsy? —

What confirmed diagnosis Phy History

(Signed) Geo Elmer Blades, M. D.

, 19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Apr 5 1929
20 UNDERTAKER	ADDRESS 1027 Hand Ave
Chas H. Trader	

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 44752

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 44752

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. St. Joseph's Hosp. ST. 1724 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emma King

(a) RESIDENCE NO. 1214 Druid Hill Ave. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
39	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establisament in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) S. C.

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) S.C.

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S.C.

14 Informant Mordecai King

(Address) 1342 Druid Hill Ave

Filed 5 1929 C. HARRISON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/2/29.

17 I HEREBY CERTIFY, That I attended deceased from 3/29/29, 19..., to 4/2/29, 19...,

that I last saw h... alive on 4/2/29, 19...

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Cardio-Vascular Disease.

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerotic Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Symptoms

(Signed) Louis G. Litton, M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	4-5 1929
20 UNDERTAKER Diamond Harris	ADDRESS 916 Cath

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44753

CERTIFICATE OF DEATH

90 E 44753

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3414 Auchentorolly Ter. ST. 9-59 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Hattie Ellison

(a) RESIDENCE NO. 3414 Auchentorolly Terrace ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Col	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rafaddel Ellison

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Isaac Berman

11 BIRTHPLACE OF FATHER (city or town) (State or country) X

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Levis
(Address) 1439 E Balto St

15 Filed 5-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 5, 1928, to April 4, 1929, that I last saw her alive on April 3, 1929, and that death occurred, on the date stated above, at 5.25 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial disease, mitral insufficiency Heart Block (1½ years)

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Graduate myocardial insufficiency (duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) Frank R Smith, M. D.

4/4, 1929 (Address) 927 E. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Hebrew Rest — DATE OF BURIAL 4/6 1929

20 UNDERTAKER Jack Levis — ADDRESS 1439 E Balto St

Spec.—2-29-28—L. F. S.—500 Bks.

E 44754

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 44754

REGISTERED NO. 17-51

1—PLACE OF DEATH

CITY OF BALTIMORE; (No.) 2100 (Street) Maryland St. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Gittinger

(a) RESIDENCE NO. 2100 (Usual place of abode) Maryland St., 12 WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. 9 mos. 29 ds. How long in U. S., if foreign birth 67 yrs. 9 mos. 29 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie R. Gittinger

6 DATE OF BIRTH (month, day, and year) June 5 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	9	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Confectioners Supplies

(c) Name of employer Habicht Braun Co.

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER William Gittinger

11 BIRTHPLACE OF FATHER (city or town) Frederick (State or country) Maryland

12 MAIDEN NAME OF MOTHER Anne Brengle

13 BIRTHPLACE OF MOTHER (city or town) Frederick (State or country) Maryland

14 Informant Mrs. Jennie R. Gittinger (wife)

(Address) 2100 Maryland St.

Filed APR 5 1929, 19... C. HAMPSON JONES, M. D. Registrar

By ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3rd 1929

17 I HEREBY CERTIFY, That I attended deceased from December 30, 1928, to April 3rd, 1929, that I last saw h[illegible] alive on April 1st, 1929, and that death occurred, on the date stated above, at 9:45 a.m.

The CAUSE OF DEATH* was as follows:

Chronic hypertension with hypertension

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral apoplexy

(duration) 1 yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) Robert L. Mitchell, M. D.

4/3, 1929 (Address) 711 W. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Apr. 6 1929
20 UNDERTAKER	ADDRESS
Edward Hopson Company	Balto.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 44755 — PLACE OF DEATH

E 44755 — REGISTERED NO.

City of BALTIMORE: (No. Mercy Hospital St. 12-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Kelly

(a) RESIDENCE NO. 2104 Greenmount Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 1869

7 AGE	Years	Months	Days
	59	8	

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland (State or country)

PARENTS

10 NAME OF FATHER Michael Kelly

11 BIRTHPLACE OF FATHER (City or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Kelly

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Ireland

14 Informant Mrs Thos Flanagan

(Address) 2110 Maryland Ave

15 Filed 5-7-1929 C. HAMILTON JONES M.D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/3/29 19

17 I HEREBY CERTIFY, That I attended deceased from 3/29/29, 19, to 4/3/29, 19, that I last saw him alive on 4/3/29, 19, and that death occurred, on the date stated above, at 3.45 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Terminal Bronchitis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) J. S. Whitehead, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

St Joseph Cem Texas Md 5/6/29

20 UNDERTAKER — ADDRESS

Geo A Foley Sucsr Bgld

very important. See instructions on back of certificates. Exact statement of OCCUPATION is

Spec.—2-29-28—L. F. S.—500 Bks.

Bessie Bonansky.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44756

CERTIFICATE OF DEATH

E 44756

1—PLACE OF DEATH 4002 Carlisle Ave

CITY OF BALTIMORE: (No. 4002 Carlisle Ave., ST., 15-65 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Bessie Bonansky

(a) RESIDENCE NO. 4002 Carlisle Ave ST., ... WARD
(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. ... mos. ... ds. How long in U. S., if foreign birth? 40 yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Samuel Bonansky

6 DATE OF BIRTH (month, day, and year): 1869

7 AGE — Years: 60 | Months: | Days: | If LESS than 1 day, ... hrs. or ... min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Said to —

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Sisk —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: J. Lewis

(Address) 1439 Eutaw Pl

15 Filed ..... C. HAMPSON JONES, M. D.

MAR 5 1929 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-4-29

17 I HEREBY CERTIFY, That I attended deceased from Jan 13, 1929 to April 4, 1929, that I last saw h[er] alive on April 4, 1929, and that death occurred, on the date stated above, at 3:30 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of oesophagus

(duration) ... yrs. 6 mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of

Was there an autopsy? ...

What test confirmed diagnosis?

(Signed) Samuel Theodore Thomas, M. D.

, 19 (Address) 1810 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Green Mount Cem

DATE OF BURIAL: 4-5 1929

20 UNDERTAKER: Jos Lewis, 1439

ADDRESS: Eutaw St

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44757

CERTIFICATE OF DEATH.

E 44757

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1723 Edmondson Ave (Ward) 21

2-FULL NAME Robert Fusselbaugh Gibson

(a) RESIDENCE NO. 1723 Edmondson Ave, Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Agnes H Gibson

6 DATE OF BIRTH (month, day, and year) Aug 22nd 1864

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	64	7	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Book Keeper

(b) General nature of industry, business, or establishment in which employed (or employer) Herda Elect. Co.

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore Md,

PARENTS

10 NAME OF FATHER Joseph Gibson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto Md

12 MAIDEN NAME OF MOTHER Margaret Ann Fusselbaugh

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore Md

14 Informant Agnes H. Gibson

(Address) 1723 Edmondson Ave

Filed APR 5 - 1929 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2nd 1929,

17 I HEREBY CERTIFY, That I attended deceased from March 1st, 1929, to April 3rd, 1929, that I last saw h[illegible] alive on April 2nd, 1929 and that death occurred, on the date stated above, at 1 a, m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Infection from teeth

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. C. Fitzpatrick, M. D.

19 (Address) 2350 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem. Date of Burial apr 5 1929

20 UNDERTAKER L. P. Fusselbaugh ADDRESS 2620 St Paul St

Very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44758

CERTIFICATE OF DEATH

44 E 44758

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2612 Evergreen Ave. ST. Hamilton 21-53 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth B. Kriemers

(a) RESIDENCE NO. 2612 Evergreen Ave ST.,
(Usual place of abode)

WARD

Length of residence in city or town where death occurred 41 yrs. 9 mos. 18 ds. How long in U. S., if foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of John Kriemers

6 DATE OF BIRTH (month, day, and year) June 16 1887

7 AGE: Years 41 | Months 9 | Days 18 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employee

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Wm. Kruempelman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Teresa Topp

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. John Kriemers

(Address) 2612 Evergreen Ave

15 Filed 1929 (19) HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4 1929

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1929, to April 4, 1929, that I last saw her alive on April 3, 1929, and that death occurred, on the date stated above, at 7:15 a. m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) H. S. Gerry M.D., M. D.

4/4, 1929 (Address) 622 W. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: 4/6 1929

UNDERTAKER: Henry Hoeck Sons, Inc. — ADDRESS: 1301 E Eager St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44759 — 94-0 — E 44759

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Rear 5111 Anthony Ave. Gardenville ST. 26-41 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Hergenhahn

(a) RESIDENCE NO. Rear 5111 Anthony Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. — mos. — ds. How long in U. S., if foreign birth? 12 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of ~~(or) WIFE~~ of Sophia Hergenhahn

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	47	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs Sophia Hergenhahn

(Address) Rear 5111 Anthony Ave

15 Filed ..., 19.. C. HERBERT JONES, M. D. Registrar

APR 5 - 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4 1929

17 I HEREBY CERTIFY, That I attended deceased from March 19 29, to April 4 19 29, that I last saw him alive on April 3 1930 19 29 and that death occurred, on the date stated above, at 1 - A. m.

The CAUSE OF DEATH* was as follows:

Diffuse Peritonitis

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Hernia 4 da

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. E. Coker M. D.

April 4, 19 29 (Address) 1104 E Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Apr. 6 19 29
20 UNDERTAKER Henry Hoeck Sons, Inc.	ADDRESS 1301 E Eager St

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44760 90 E 44760

CERTIFICATE OF DEATH.

11-24

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Basin Manufacturing Co. St., Fairfield Ward)

2-FULL NAME William Davis.(C)

(a) RESIDENCE NO. 433 N. Biddle St. St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	Colored	Married.

5a If married, widowed or divorced HUSBAND of WIFE of Isabelle Davis.(C)

6 DATE OF BIRTH (month, day, and year) November 1, 1881.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	47	5	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Virginia

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Do not know.

14 Informant Isabelle Davis.(C) wife.

(Address) 433 N. Biddle St.

Filed APR 5 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute dilatation of the Heart.

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

(Signed) ... M. D.
(Coroner)

4/4, 19 29 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ...yrs. ...mos. ...ds. In the State ...yrs. ...mos. ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary Date of Burial Apr. 6 1929

20 UNDERTAKER Mrs. R. G. Elliott ADDRESS 1245 Ashland Ave

very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 44761

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 44761

REGISTERED NO. 2332

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1617 Race. ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank. I. Kinsey.

(a) RESIDENCE NO. 1617 Race ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 59 yrs. 10 mos. 23 ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Kinsey.

6 DATE OF BIRTH (month, day, and year) May. 11. 1870.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
58	59.	10.	23.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Day Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer) Davis Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Dont know.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dont know

12 MAIDEN NAME OF MOTHER Dont know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont Know.

14 Informant Mrs Kinsey (Address) 701 W. Lafayette Ave

15 Filed 1929. C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4/29

17 I HEREBY CERTIFY, That I attended deceased from Mar 1, 1929, to April 4, 1929

that I last saw h alive on April 3, 1929

and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Primal Regurgitation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) R. K. Campbell, M. D.

4/5, 1929 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	April 6, 1929

20 UNDERTAKER A. H. and Evans ADDRESS 386 E. Fort Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44762

CERTIFICATE OF DEATH

REGISTERED NO. E 44762

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 719 Mc Cabe Ave ST., 27-48 WARD)

2—FULL NAME Katherine Fahey Jeanneret

(a) RESIDENCE NO. 719 Mc Cabe Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov 28. 1923

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
5	4	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

10 NAME OF FATHER Louis Jeanneret

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Loretta Fahey

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Penna

14 Informant Louis Jeanneret
(Address) 719 Mc Cabe Ave

15 APR 5 - 1929 Filed Dr. Anderson Jones, M. Registrar
By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 3 - 1929

17 I HEREBY CERTIFY, That I attended deceased from Mch 27, 1929, to Apr 3, 1929, that I last saw h[illegible] alive on Apr 3, 1929, and that death occurred, on the date stated above, at 10 05 P. m.

The CAUSE OF DEATH* was as follows:

"Shock" due to acute dilatation Stomach & heart due to indiscretion diet

(duration) 10 mins yrs. mos. ds.

CONTRIBUTORY (Secondary) Measles

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H W Wheaton, M. D.

, 19 (Address) 4305 York Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: April 5. 1929

20 UNDERTAKER: Wm Cook — ADDRESS: 1217 St Paul St

Spec.—2-29-28—L. F. S.—500 Bks.

E 44763

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 44763

1—PLACE OF DEATH

REGISTERED NO. 15-59

CITY OF BALTIMORE: (No. Ft. Balt. Gen. Hosp. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Miss Bertha May Martin.

(a) RESIDENCE NO. 2130 N. Fulton Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. 1 mos. 27 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 7, 1905

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	24	1	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waitress

(b) General nature of industry, business, or establishment in which employed (or employer) Restaurant

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Wm H. Martin

11 BIRTHPLACE OF FATHER (city or town) Ind. (State or country)

12 MAIDEN NAME OF MOTHER Hallie Carroll

13 BIRTHPLACE OF MOTHER (city or town) Minneapolis (State or country) Minn

14 Informant Hospital Records.

(Address)

15 Filed 4/5 1929 HAMILTON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/4/29

17 I HEREBY CERTIFY, That I attended deceased from 4/1, 1929, to 4/4, 1929, that I last saw her alive on 4/4, 1929 and that death occurred, on the date stated above, at 9 55 p. m.

The CAUSE OF DEATH* was as follows:

Bronchial Asthma

(duration) 12 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 2130 N. Fulton Ave.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) L. Featherstone, M. D.

4/7, 1929 (Address) Ft. Balto. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge

DATE OF BURIAL 4/8 1929

20 UNDERTAKER Veirons Coote

ADDRESS 1217 St Paul

Spec.—2-29-28—L. F. S.—500 Bks.

E 44764

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44764

CERTIFICATE OF DEATH

1—PLACE OF DEATH Union Memorial Hospital REGISTERED NO. 78

CITY OF BALTIMORE: (No. 3200 Calvert ST. S 13-54 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jane Childress

(a) RESIDENCE NO. 817 Whitelock ST., City WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (Write the word): Child

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: ✓

6 DATE OF BIRTH (month, day, and year): Feb. 2, 1927

7 AGE — Years: 2 | Months: 2 | Days: 2 | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ✓

(b) General nature of industry, business, or establishment in which employed (or employer): ✓

(c) Name of employer:

9 BIRTHPLACE (city or town): Baltimore
(State or country) Maryland

10 NAME OF FATHER: William J Childress

11 BIRTHPLACE OF FATHER (city or town):
(State or country) Virginia

12 MAIDEN NAME OF MOTHER: Malvina Color

13 BIRTHPLACE OF MOTHER (city or town):
(State or country) New York

14 Informant: Mother (Address) 817 Whitelock St.

Filed APR 5 - 1929 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 4 1929

17 I HEREBY CERTIFY, That I attended deceased from 4/4, 19 29, to 4/4, 19 29, that I last saw h[illegible] alive on 4/4, 19 29 and that death occurred, on the date stated above, at 9.51 P m.

The CAUSE OF DEATH* was as follows:

Epilepsy

(duration) 1 yrs. 7 mos. F ds.

CONTRIBUTORY (Secondary) Status Epilepticus

(duration) yrs. mos. ds.

18 Where was disease contracted; if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Path & Neg. Spinal Fld.

(Signed) Wallace Swarbrick, M. D.

19 (Address) Union Memorial Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	4/8 19 29
20 UNDERTAKER: William Cook	ADDRESS: 1217 St Paul

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44765

CERTIFICATE OF DEATH

90 ✓

E 44765

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 7210 Harford rd ST. 17-43 WARD 3

2—FULL NAME George R. Froehlick

(a) RESIDENCE NO. 7210 Harford rd WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillie M. Froehlick

6 DATE OF BIRTH (month, day, and year) Jan 25 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	4	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Lumberman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer self 045

9 BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER Henri Froehlick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Katherine Reinade

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mrs A. Hall

(Address) 7210 Harford rd

15 Filed 5-1 1929 C. HAMILTON JONES, M. Registrar

Pat

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4th 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 28 1928 to April 4 1929.

that I last saw him alive on April 4 1929

and that death occurred, on the date stated above, at 3 55 P m.

The CAUSE OF DEATH* was as follows:

Endocarditis, chronic; septicaemia (positive blood-culture streptococcus hemolyticus)

(duration) more than yrs. 4 mos. 6 ds.

CONTRIBUTORY (Secondary) meningitis (streptococcus)

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? —

What test confirmed diagnosis? Blood culture (2)

(Signed) A. M. Bacon, M. D.

(Address) Parkville, Md. 4/4 1929

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Apl 6-29
20 UNDERTAKER	ADDRESS
Reitamn & Poe	1723 W Lafayette Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44766

CERTIFICATE OF DEATH

90 E 44766

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Baltimore City Hosp ST., 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Nelson

(a) RESIDENCE NO. 514 E 21st ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred (yrs. 5 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of single

6 DATE OF BIRTH (month, day, and year) July 12 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	8	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pork Packer

(b) General nature of industry, business, or establishment in which employed (or employer) Hohman

(c) Name of employer Hohman

9 BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER Joseph Nelson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Mary Lee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

PARENTS

14 Informant Baltimore City Hospital

(Address)

15 Filed 4-5 1929 19 HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/4/29

17 I HEREBY CERTIFY, That I attended deceased from 3/1 1929 to 4/4 1929

that I last saw him alive on 4/4 1929

and that death occurred, on the date stated above, at 3-4 m.

The CAUSE OF DEATH* was as follows:

Cyanosis & Asthenia

Myocarditis

Chr. Asthenia to Pleuritis

Empyema Left Lung

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of 3/19/29

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) R. H. Welch, M. D.

19 (Address) Balto City Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL April 6 1929

20 UNDERTAKER Frank V. Lipitone

ADDRESS 2518 E. Baltimore St

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44767

CERTIFICATE OF DEATH.

100-001

E 44767
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1215 Edmonson (St.) 16-16 (WARD)

2-FULL NAME Robert Henson

(a) RESIDENCE NO. 1215 Edmonson ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): March 30 1929

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

PARENTS

9 BIRTHPLACE (city or town) (State or country): Balto md

10 NAME OF FATHER: Robt Henson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Eva Matthews

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Mary Matthews
(Address) 1215 Edmonson ave.

15 Filed 5 1929, 19 HAMPSON JONES, M. D. Registrar
Par

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 4 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb 24, 1929, to April 4, 1929, that I last saw him alive on Mar 28, 1929 and that death occurred, on the date stated above, at 6.20 p m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Geo Woolridge, M. D.

4-4 1929 (Address) 703 N Loffette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary Cemtry — DATE OF BURIAL: 4/5 1929

UNDERTAKER: Walter B. Sprigg — ADDRESS: 134 N. Hamilton Ave

THIS IS very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500.Blks.

E 44768 HEALTH DEPARTMENT—CITY OF BALTIMORE E 44768

CERTIFICATE OF DEATH.

101-06

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 539 Bloom St. 16-22 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Edward Alston

(a) RESIDENCE NO. 1400 W. Lanvale St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred all his life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Col.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence Alston

6 DATE OF BIRTH (month, day, and year) Aug 5th 1901

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
28	27	7	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Moving Picture Porter

(b) General nature of industry, business, or establishment in which employed (or employer) Moving Picture Ind.

(c) Name of employer S. Oletsky 070

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Joseph Alston

11 BIRTHPLACE OF FATHER (city or town) Henderson
(State or country) N. C.

12 MAIDEN NAME OF MOTHER Carrie Caton

13 BIRTHPLACE OF MOTHER (city or town) Henderson
(State or country) N. C.

14 Informant Carrie Alston
(Address) 539 Bloom St.

15 Filed 1929 HAMILTON BOYD JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-3 1929

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1929, to April 3, 1929, that I last saw him alive on April 3, 1929, and that death occurred, on the date stated above, at 7-10 P. m.

The CAUSE OF DEATH* was as follows:

Croupous Pneumonia

Possibly about a wk
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Sudden cardiac failure
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balto., Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) Edwardfield Doyle, M. D.

4/4, 1929 (Address) 826 N. Carrollton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cem	4-6th 1929
20 UNDERTAKER	ADDRESS
Jas. M. Skinner	1620 E. Monument St

TION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

223830

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 44769

CERTIFICATE OF DEATH

E 44769

1—PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 26-37 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Eleanora Bradstock

(a) RESIDENCE NO. 527 S. 45th St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Single

6 DATE OF BIRTH (month, day, and year) May 2 1927

7 AGE: Years 1 Months 11 Days 2 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md

10 NAME OF FATHER: Alden

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa

12 MAIDEN NAME OF MOTHER: Helena Reinhart

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

Filed APR 5 1929, H. HANSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4 1929

17 I HEREBY CERTIFY, That I attended deceased from March 28, 1929, to April 4, 1929, that I last saw her alive on April 4, 1929 and that death occurred, on the date stated above, at 8 20 P. m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary): otitis media

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray

(Signed) S. C. Goodwin, M. D.

4/5, 1929 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn — DATE OF BURIAL: April 7 1929

20 UNDERTAKER: M. W. E. Hoppel Sons — ADDRESS: 32 Lanvale

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44770

E 44770

CERTIFICATE OF DEATH

101-001

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS

REGISTERED NO. E 44770

CITY OF BALTIMORE: (No. ..... ST., 11-2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry Thomas

(a) RESIDENCE NO. 1011 McCulloh ST., ... WARD
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Alabama

PARENTS

10 NAME OF FATHER: John Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country): Alabama

12 MAIDEN NAME OF MOTHER: Ann ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Alabama

14 Informant: Records of BALTIMORE CITY HOSPITALS (Address)

15 Filed APR 5 - 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 1, 1929

17

I HEREBY CERTIFY, That I attended deceased from December 10, 1927 to April 1, 1929.

that I last saw him alive on April 1, 1929

and that death occurred, on the date stated above, at 12:45 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

..... (duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no What test confirmed diagnosis? Physical Exam

(Signed) P. M. Stock, M. D.

, 19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: VERSITY OF MARYLAND

DATE OF BURIAL: 19

UNDERTAKER: [illegible] Health.

ADDRESS [illegible] APR 5 - 1929

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44771

CERTIFICATE OF DEATH.

31

E 44771

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1378 Spring St. 3-4 Ward)

2-FULL NAME Thomas Wesh

(a) RESIDENCE NO. 137 S Spring St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Mab	W	unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
about	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work unknown

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)

(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant

(Address)

15 Filed _____ 19____ C. HARRISON JONES, M. D. Registrar

1825

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 3 29 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) Alcoholism

(duration) ____ yrs. ____ mos. ____ ds.

(Signed) James M Hendrix, M. D.
(Coroner)

3 29 1929 (Address) 705 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL

Date of Burial 19

20 UNDERTAKER

ADDRESS

Commissioner Health.

APR 5 - 1929

UNIVERSITY OF MARYLAND

Very Important. See instructions on back of certificate.

E 44772

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 44772

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 589 Oxford. St. 17-25 Ward)

2-FULL NAME Homer Stiles

(a) RESIDENCE NO. 589 Oxford. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosie Stiles

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
52	51			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Georgia.
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) Georgia
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) Georgia
(State or country)

14 Informant Rosie Stiles.
(Address) 589 Oxford

15 Filed ..... 19 ..... Registrar

APR - 1929

THE SUN

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) March 18 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(duration) ..... yrs. ..... mos. Hours

CONTRIBUTORY (Secondary) Error of diet

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? Home,

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. Blank, M. D.

March 18 1929 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health.

ADDRESS

APR 5 - 1929

HAMPSON JONES, M. D.

3455

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 44773

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44773

CERTIFICATE OF DEATH

129

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1007 Rutland ave ST., 7-13 WARD)

2—FULL NAME Susan L. Griffin

(a) RESIDENCE NO. 1007 Rutland ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced (or) WIFE of: Charles H. Griffin

6 DATE OF BIRTH (month, day, and year): May 8th 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	81	10	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Maryland

PARENTS

10 NAME OF FATHER: Andrew Edell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Calvert Co Md

12 MAIDEN NAME OF MOTHER: Sarah J. Whittington

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Calvert Co Md

14 Informant: Dorothy Griffon

(Address): 1007 Rutland ave

15 Filed 4/7 1929 Gr. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 3rd 1929

17 I HEREBY CERTIFY, That I attended deceased from June 1 1921 to April 3 1929

that I last saw her alive on April 3 1929

and that death occurred, on the date stated above, at 10.25 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. C. Richardson M. D.

1929 (Address) 1120 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	April 6th 1929
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1136 Eutaw St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44774

CERTIFICATE OF DEATH

E 44774
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 2517 Talbot Rd 28-65 (Ward)

2-FULL NAME Mobillian M. McCracken

(a) RESIDENCE NO. 2517 Talbot Road Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Johanna McCracken

6 DATE OF BIRTH (month, day, and year) June 18 1871

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
58	57	9	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Draftsman
(b) General nature of industry, business, or establishment in which employed (or employer) B & O R R
(c) Name of employer

9 BIRTHPLACE (city or town) Ohio
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Mrs. Bassett S. Mace
(Address) 2306 Sulgreve Ave.

15 Apr 1929, 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) April 3rd 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage Sudden

(duration) yrs. mos.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) F. E. Klinck, M. D.
April 4th 1929 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Toledo, Ohio — DATE OF BURIAL April 5, 1929

20 UNDERTAKER Oswald Cook — ADDRESS 1033 West Baltimore St

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 44775

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001 E 44775

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 223 W. 29th ST. 12-5 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Eliza Jane Elder

(a) RESIDENCE NO. 223 W. 29th ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Levi M. Elder

6 DATE OF BIRTH (month, day, and year) October 31, 184[illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	5	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Sykesville
(State or country) Maryland

PARENTS

10 NAME OF FATHER William Lilly

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Mr. William M. Elder

(Address) 3210 Liberty Heights Ave.

Filed 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4, 1929

17 I HEREBY CERTIFY, That I attended deceased from Mar. 30, 1929, to Apl 4, 1929, that I last saw her alive on Apl 4, 1929, and that death occurred, on the date stated above, at 9.50 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Arthur C. Blake, M. D.

4/5, 1929 (Address) 216 E. University Pkwy.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL April 6 1929

20 UNDERTAKER [illegible]

ADDRESS 1053 West Baltimore St

Spec.—2-29-28—L. F. S.—500 Bks.

E 44776

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-001

E 44776

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2321 E. Baltimore ST., 6-10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME August Kriegel

(a) RESIDENCE NO. 2321 E. Baltimore ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? ? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Barbara Kriegel.

6 DATE OF BIRTH (month, day, and year) Oct 14-1842

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	87	5	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cartmaker

(b) General nature of industry, business, or establishment in which employed (or employer) Self Emp.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Frank Kriegel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Barbara Kriegel Wife

(Address) 2321 E. Baltimore St

15 Filed ..., 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3/29

17

I HEREBY CERTIFY, That I attended deceased from Mar 1, 1929, to April 3, 1929

that I last saw h... alive on Mar 31, 1929

and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Old age

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) ... yrs. ... mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) O. T. Roder, M. D.

, 19 (Address) 1904 Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Apr. 6 19 29

20 UNDERTAKER Dec. ADDRESS 4038 Wabash

Spec.—2-29-28—L. F. S.—500 Blks.

E 44777

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44777

CERTIFICATE OF DEATH

113

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 309 S. Wolfe St. ST. 7-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Cecilia Teresa Babicki

(a) RESIDENCE NO. 309 S Wolfe st ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 9-28

7 AGE Years | Months 7 | Days 23 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER Mikolay.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Cecilia Szczublewska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

PARENTS

14 Informant Mikolaj Babicki

(Address) 309 S. Wolfe St

Filed Apr 5, 1929 C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 4- 1929

17 I HEREBY CERTIFY, That I attended deceased from Apr 2nd, 1929, to Apr 4th, 1929,

that I last saw h[illegible] alive on Apr 4th, 1929

and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

2 Claudia

due to Tuberculosis Pulmonalis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Henrik J Grenig, M. D.

Apr 5, 1929 (Address) 1400 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart of Mary Apr. 6 1929

DATE OF BURIAL

20 UNDERTAKER F W Ozazewski

ADDRESS 1930 Eastern Ave

Spec—12-23-21—E.B.R.S.—400 Bks.

E 44778 HEALTH DEPARTMENT—CITY OF BALTIMORE E 44778

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 1617 Fleet St. 2-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Maryanna Burzycki

(a) Residence No. 1617 Fleet St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 39 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, ~~Widowed~~, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or WIFE of) James Burzycki

6-DATE OF BIRTH (month, day and year) 1857

7-AGE. 72 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. housework

(b) General nature of industry, business, or establishment in which employed (or employer). ~~do~~

(c) Name of employer.....

9-BIRTHPLACE (city or town). (State or Country), Poland

PARENTS.

10-NAME OF FATHER. Joe Ostrowski

11-BIRTHPLACE OF FATHER (city or town). (State or Country), Poland

12-MAIDEN NAME OF MOTHER. unk.

13-BIRTHPLACE OF MOTHER (city or town). (State or Country), Poland

14- (Informant) Mrs Majka

(Address) 1617 Fleet St

15- Filed 4-2 1929 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 2-29

17- I HEREBY CERTIFY, That I attended deceased from March 30, 1929 to April 2, 1929 that I last saw h.. alive on April 2 1929 and that death occurred, on the date stated above, at 5 P. M.

The CAUSE OF DEATH* was as follows:

Anaemia
Chronic nephritis
Myocardial insufficiency

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Andrew Rumowski M. D.

4/3, 1929 (Address) 2329 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Rosary DATE OF BURIAL. April 6. 1929

20-UNDERTAKER. F. W. Ozazenski ADDRESS 1980 Eastern Ave

Spec.—2-29-28—L. F. S.—500 Blks.

E 44779

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

E 44779

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 122 E. Fort Ave. ST. 14-33 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Clemintine Nunnally

(a) RESIDENCE NO. 122 E. Fort Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 73 yrs. 1 mos. 1 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Columbus Nunnally

6 DATE OF BIRTH (month, day, and year) Mar. 3 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md (State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Mr. Columbus Nunnaly

(Address)

15 Filed 4-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/4/29

17 I HEREBY CERTIFY, That I attended deceased from 4/2, 19 , to 4/4, 1929, that I last saw her alive on 4/3, 1929 and that death occurred, on the date stated above, at 11.10 a.m.

The CAUSE OF DEATH* was as follows: Bronchial Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Valvular Heart Disease (duration) 2 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. C. Coen, M. D.

4/4, 1929 (Address) 390 Hanover Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery

DATE OF BURIAL 4/6 1929

20 UNDERTAKER S. From Nill & Cully

ADDRESS 130 E Fort

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44780

CERTIFICATE OF DEATH

90

E 44780

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 122 N. Camden St. St., 22-30 Ward)

2-FULL NAME Steve Podchornik. (Polton)

(a) RESIDENCE NO. 122 N. Camden St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. — mos. — ds. How long in U. S., if of foreign birth? 15 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —;——

6 DATE OF BIRTH (month, day, and year) March 27, 1896

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	33	0	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Saloon Keeper
(b) General nature of industry, business, or establishment in which employed (or employer) Self
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Russia.

PARENTS

10 NAME OF FATHER John Podchornik

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia.

14 Informant George Podchornik. (brother)
(Address) 29 S. Robinson St.

15 Filed 5-1929 C. HAMPSON JONES, M. D. Registrar.
By ——

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to Res death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute dilatation of the Heart.
Acute congestion of the Lungs.

(duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary)

(duration) ..yrs. ..mos. ..ds.

18 Where was disease contracted If not at place of death? Res.

Did an operation precede death? No. Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy.

(Signed) Otto M. Reinhardt, M. D.

4/4, 1929 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Trinity. A. A. Co. Inf	4/6 1929
20 UNDERTAKER William Fialkowski	ADDRESS 1618 Eastern Ave

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44781

CERTIFICATE OF DEATH

90 E 44781

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 5004 Roland Ave ST. 13-57 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary M. Ritter

(a) RESIDENCE NO. 5004 Roland Ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm H. Ritter

7 DATE OF BIRTH (month, day, and year): July 11-1876

8 AGE: Years 52 Months 8 Days If LESS than 1 day, hrs. or min.

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Baltimore Md

10 NAME OF FATHER: Adam Schmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Grosslander

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

Informant: Wm H. Ritter

(Address) 5004 Roland Ave

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 4-29

17 I HEREBY CERTIFY, That I attended deceased from March 29 19 29 to April 4 19 29

that I last saw her alive on Apr 4 19 29

and that death occurred, on the date stated above, at 10 AM

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Myocardial Dilitation

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Eugene Shapard, M. D.

19 (Address) 206 W Lafayette Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: 4/6 1929

20 UNDERTAKER: Wm Cook

ADDRESS: 121 St Paul

- 1929

Spec.—2-29-28—L. F. S.—500 Bks.

Dr Hoag
724 Wash Blvd

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44782

CERTIFICATE OF DEATH

31 ✓ E 44782

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1631 Montpelier ST., 7-44 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Reeves R. Grimes

(a) RESIDENCE NO. 1631 Montepelier ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Sarah Grimes

6 DATE OF BIRTH (month, day, and year) [illegible] 1880

7 AGE: Years 48 | Months 9 | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Produce Dealer

(b) General nature of industry, business, or establishment in which employed (or employer): Sales

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

10 NAME OF FATHER: Frank Grimes

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

Informant: Donald Grimes

(Address): 2127 Wilkens Ave

FILED 1929 C. HAMPSON JONES, M. D. Registrar

Dat

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 4-29

17

I HEREBY CERTIFY, That I attended deceased from Feb. 6, 1929, to April 4, 1929, that I last saw h[illegible] alive on April 2, 1929 and that death occurred, on the date stated above, at 10:20 P m.

The CAUSE OF DEATH* was as follows:

Acute Miliary Pulmonary Tuberculosis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary): Influenza + Bronchitis

(duration) yrs. 2 mos. 15 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Wesley Hoag, M. D.

Apr 5. 1929 (Address) 724 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn

DATE OF BURIAL: 4 8 1929

20 UNDERTAKER: William Cook

ADDRESS: 1217 St Paul

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44783 CERTIFICATE OF DEATH X 179 E 44783

1—PLACE OF DEATH REGISTERED NO.

CITY OF BALTIMORE: (No. University Hospital 4-30 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Helen Robinson

(a) RESIDENCE NO. Essex, Md. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Lester Robinson

6 DATE OF BIRTH (month, day, and year): Dec. 6, 1901

7 AGE: Years 27 | Months 3 | Days 28 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Kentucky

10 NAME OF FATHER: Farmer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: C. Lester Robinson

(Address): Essex, Md.

15 Filed 5 1929, 19 By C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 4 1929

17 I HEREBY CERTIFY, That I attended deceased from March 24, 1929, to April 4, 1929, that I last saw her alive on April 4, 1929, and that death occurred, on the date stated above, at 6:00 P m.

The CAUSE OF DEATH* was as follows:

Cyanosis of face, neck, thorax & all extremities

(duration) yrs. 5 mos. 16 ds.

CONTRIBUTORY (Secondary): Acute nephritis

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Physical Examination

(Signed) L. C. Lumpkin, M. D.

4/4. 1929 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Green's Cem. Stemmers Run

DATE OF BURIAL: 4/6 1929

20 UNDERTAKER: John G. Connelly

ADDRESS: Essex

Spec.—2-29-28—L. F. S.—600 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44784

CERTIFICATE OF DEATH

37-001

E 44784

1—PLACE OF DEATH

REGISTERED NO. 19-28

CITY OF BALTIMORE: (No. 341 S. Monroe ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elaine Catherine Smardon

(a) RESIDENCE NO. 341 S. Monroe ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) October 6, 1928

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	-	5	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER George I. Smardon

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Edith L. Hunter

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mr. George I. Smardon
(Address) 341 S. Monroe St.

15 Filed 5-1929, 19 Per C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5, 1929

17 I HEREBY CERTIFY, That I attended deceased from Mar 24, 19 29 to Apr 5, 19 29

that I last saw her alive on Apr 5, 19 29

and that death occurred, on the date stated above, at 12.50 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) — yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Miliary Tuberculosis

(duration) yrs. 1 mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Findings

(Signed) Jas. L. Gaskins, M. D.

4/5, 1929 (Address) 1729 E. Lombard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	April 6 19 29
20 UNDERTAKER Wm. H. Cook	ADDRESS 1009 West Baltimore St.

Spec.—2-29-28—L. F. S.—500 Blks.

E 44785

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 44785

1—PLACE OF DEATH

REGISTERED NO. 14-20

CITY OF BALTIMORE: (No. 1805 Eutaw Place ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles David Kreis

(a) RESIDENCE NO. 1805 Eutaw Place ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Weber Kreis

6 DATE OF BIRTH (month, day, and year) December 9, 18[illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	69	3	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired from [illegible]

(b) General nature of industry, business, or establishment in which employed (or employer) Baltimore Barrein House

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER George W. Kreis

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary E. Irelan

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mrs. Annie Weber Kreis
(Address) 1805 Eutaw Place

15 Filed [illegible] 19 29 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4, 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 15, 1929, to Apr. 3, 1929, that I last saw him alive on Apr. 2, 1929 and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) B. Kadan, M. D.

, 19 (Address) 2306 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	April 6 1929
20 UNDERTAKER [illegible]	ADDRESS 1003 West Baltimore St

Spec.—1-10-21 M&T [illegible] E 44786

HEALTH DEPARTMENT—CITY OF BALTIMORE E 44786

CERTIFICATE OF DEATH.

33

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1540 Mc Elderry ST., 7-4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alonzo Johnson

(a) RESIDENCE NO. 1540 Mc Elderry ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mamie Johnson

6 DATE OF BIRTH (month, day, and year): April 3 1900

7 AGE: Years 29 | Months — | Days 1 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Musician

(b) General nature of industry, business, or establishment in which employed (or employer): Theatre

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Daniel Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Co.

12 MAIDEN NAME OF MOTHER: Jennie Stephney

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Jennie Johnson (mother)

(Address) 1540 Mc Elderry St

15 Filed 5-[illegible]-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 4 1929

17

I HEREBY CERTIFY, That I attended deceased from Feb. 1929, to April 4, 1929, that I last saw him alive on April 3, 1929, and that death occurred, on the date stated above, at 1.10 A. m.

The CAUSE OF DEATH* was as follows:

Pleurisy & Effusion

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) (Probably) Tuberculosis (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) R J Young, M. D.

4/4, 1929 (Address) 1429 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Calvary — DATE OF BURIAL: 4/7-29

20 UNDERTAKER: Robert S Mullen — ADDRESS: 1515 Mc Elderry St

Spec.—2-29-28—L. F. S.—500 Bks.

E 44787

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1929 E 44787

1—PLACE OF DEATH

REGISTERED NO. 20-64

CITY OF BALTIMORE (No. 2429 Christian ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary E McAuliffe

(a) RESIDENCE NO. 2429 Christian ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thomas McAuliffe

6 DATE OF BIRTH (month, day, and year): Dec 12, 1895

7 AGE: Years 33 | Months 3 | Days 23 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Home

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

10 NAME OF FATHER: Jacob Owens

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balt Md

12 MAIDEN NAME OF MOTHER: Mary Schultz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balt Md

Informant: Thomas McAuliffe

(Address) 62 Middle Branch Ave

Filed 5-1929, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 4, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1929, to April 4, 1929, that I last saw her alive on April 4, 1929 and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Acute Pancreatitis

Nephritis. Nephrosclerosis

(duration) Unknown mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Nathan C Peters, M. D.

4/5/29, 19 (Address) 2501 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western

DATE OF BURIAL: 4 8 29

20 UNDERTAKER: J M Cook

ADDRESS: 2172 Eutaw

Spec.—2-29-28—L. F. S.—500 Bks.

E 44788

HEALTH DEPARTMENT—CITY OF BALTIMORE

Zoltowski

117

E 44788

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Baltimore City Hosp ST. 112 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edward Zoltowski

(a) RESIDENCE NO. 806 S Pat ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? 47 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE — Years: 54 | Months: | Days: | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cabinet Maker

(b) General nature of industry, business, or establishment in which employed (or employer): 014

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Poland

10 NAME OF FATHER: Julius Zoltowski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Jacak?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

PARENTS

14 Informant: Baltimore City Hosp. Records

(Address)

15 Filed 5-1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/5/29

17 I HEREBY CERTIFY, That I attended deceased from 4/1, 1929, to 4/5, 1929, that I last saw h alive on 4/5, 1929, and that death occurred, on the date stated above, at 6 P.M. m.

The CAUSE OF DEATH* was as follows:

Acute Tonsilitis

Influenza

Generalized Peritonitis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unk

Did an operation precede death? Yes Date of 4/1/29

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) P. M. Veck, M. D.

, 19 (Address) Balt City Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	April 9 1929

20 UNDERTAKER: John W Weber ADDRESS: 401 N Chester St

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 44789

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44789

CERTIFICATE OF DEATH.

129

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1330 W Lombard St. 16-23 WARD)

2-FULL NAME John P. Romozer

(a) RESIDENCE. No. 1330 W. Lombard ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug 23 - 1878

7 AGE: 50 Years 7 Months 11 Days — If LESS than 1 day, hrs. or min.

51

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Chas E Romozer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Mary Daly

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: James Romozer (Address) 1330 W Lombard St.

15 Filed ... 19 ... C. HAMPSON JONES, M. D. Registrar

6 • 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr. 4 1929

17 I HEREBY CERTIFY, That I attended deceased from Apr. 3, 1927, to Apr. 4, 1929, that I last saw him alive on Apr. 3, 1929, and that death occurred, on the date stated above, at 1:30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Uremia

(duration) ... yrs. ... mos. 1½ ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) W. H. Dispeau, M. D.

19 (Address) 1324 W. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: 4-6 1929

20 UNDERTAKER: Robert Brooks & Son — ADDRESS: Calhoun Hollins

Cor.—1-12-23—M&T—100 Bks.

E 44790

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44790

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2249 Lyndnor ST. 1359 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frank Johnson

(a) RESIDENCE No. 2249 Lyndnor ST., 13 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	53			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) [illegible]
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) " "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

14 Informant Florence Dellman
(Address) 1107 Wilmington Ave

15 Filed ..... G. HAMPSON JONES, M. D. Registrar
4 - 1929 By [illegible]

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/3 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) John H. Morrison M. D.
(Coroner.)
4/5 1929 (Address) 3632 Orleans.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	April 6th 1929
20 UNDERTAKER	ADDRESS
A. Jones	111 S. Gilmor St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44791

CERTIFICATE OF DEATH

162 E 44791

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1028 N. Milton Ave) (WARD) 12

2—FULL NAME Margaret Ella Reilly

(a) RESIDENCE NO. 1028 N Milton Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, ~~Widowed, or Divorced, (write the word)~~: single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 28, 1929

7 AGE — Years | Months | Days: 8 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md

PARENTS

10 NAME OF FATHER: Michael Francis Reilly

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore, Md

12 MAIDEN NAME OF MOTHER: Margaret Rawley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Michael Francis Reilly

(Address) 1028 N Milton Ave

15 Filed: 6 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5 1929

17 I HEREBY CERTIFY, That I attended deceased from 3-28-29 to 4-5 19 29, that I last saw h alive on 4-4 19 29, and that death occurred on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Atelectasis Neonatus

Congenital

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Ledderbog M. D.

(Address) 1007 N Milton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery

DATE OF BURIAL: April 6 1929

20 UNDERTAKER: Robt F. Cunniche

ADDRESS: 1412 N Broadway

Spec—12-23-21—E.B.R.S.—400 Bks.

E 44792 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 44792

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1105 Druid Hill ave St., 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Spriggs Diggs

(a) Residence No. 1105 Druid Hill ave St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Adda Diggs

6-DATE OF BIRTH (month, day and year) — 1885

7-AGE. 44 yrs. — mos. — ds.

If LESS than 1 day, — hrs. or — min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Barber

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), West Rivr Md.

PARENTS.

10-NAME OF FATHER, John A. Diggs

11-BIRTHPLACE OF FATHER (city or town) (State or Country), West Rivr Md.

12-MAIDEN NAME OF MOTHER, Serena Turner

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), West Rivr Md.

14- (Informant). William Diggs

(Address). 819 arlington Ave

15- Filed 8-1923 192 HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4-3-29

17- I HEREBY CERTIFY, That I attended deceased from April 1st, 1929 to Apr. 3rd 19.29.

that I last saw h alive on Apr. 2nd 19.29

and that death occurred, on the date stated above, at 2:30 Am.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorhage

(Duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(Duration) — yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C M Lawrence M. D.

. 19 (Address) 1232 Mosher St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Auburn Cem

DATE OF BURIAL, 4/6 19 29

UNDERTAKER. Samuel Kemsley Jr

ADDRESS 518 N Bond

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44793

CERTIFICATE OF DEATH

129 E 44793

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. University Hospital ST., 11-24 WARD)

2—FULL NAME Bertha Bell

(a) RESIDENCE NO. 812 Little Monument ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of James Bell

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Work

(b) General nature of industry, business, or establishment in which employed (or employer) 31

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

10 NAME OF FATHER John Long

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md.
(State or country)

12 MAIDEN NAME OF MOTHER Sarah Parren

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Husband.

(Address) 812 Little Monument St

Filed APR 6 1929 19 HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/4/29

17 I HEREBY CERTIFY, That I attended deceased from 2/27, 1929, to 4/4, 1929

that I last saw h[illegible] alive on 4/4, 1929

and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Chronic Diffuse Nephritis.
Pulmonary Oedema.

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema,

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Examination &

(Signed) Henry Vincent Davis, M. D.

4-5, 1929 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cem	4/6 19 29
20 UNDERTAKER Samuel Wemsley	ADDRESS W Balto

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44794

E 44794

CERTIFICATE OF DEATH.

91-002

1-PLACE OF DEATH House of Good Shepherd

City of BALTIMORE: (No. Mount & Hollins St. 14-28 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sister Mary Loretto

(a) RESIDENCE NO. Mount & Hollins St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 3/4/1854

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	75	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sister

(b) General nature of industry, business, or establishment in which employed (or employer): 065

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Ireland

PARENTS

10 NAME OF FATHER Do not Know

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Do not Know

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Sisters of Good Shepherd

(Address) Mount & Hollins

Filed 4/6 19 29 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/5 1929

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1929, to April 5, 1929, that I last saw h[illegible] alive on April 4, 1929, and that death occurred, on the date stated above, at 7.0 m.

The CAUSE OF DEATH* was as follows:

Cerebro Pulmonia

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw. V. Kovalchan M. D.

4/5/29 (Address) 224 E. Fallis Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — Date of Burial: 4/6 1929

20 UNDERTAKER: J. J. Fahey & Sons — ADDRESS: 1318 Light

Very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 44795 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44795

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 824 McKean Ave (16-22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. Prussing

(a) RESIDENCE NO. 824 Mc. Kean Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of ~~or) WIFE of~~ Caroline Prussing

6 DATE OF BIRTH (month, day, and year) July 22 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	8	13	17

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER John H. Prussing

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Inkhouse

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John H. Prussing Jr. (Address) 824 Mc Kean Ave

15 Filed 9 11 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4 1929

17 I HEREBY CERTIFY, That I attended deceased from July 30, 1927, to Apr 4, 1929, that I last saw h[illegible] alive on Apr 4, 1929, and that death occurred, on the date stated above, at 1P m.

The CAUSE OF DEATH* was as follows:

Chronic hypertension

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) Acute pulmonary edema

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) Robert [illegible] Mitchell, M. D.

4/6, 1929 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel — DATE OF BURIAL April 8 1929

20 UNDERTAKER Josiah Syfer — ADDRESS 1600 N. Nork

Spec.—1-12-23—M&T—500 Bks.

E 44796

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44796

CERTIFICATE OF DEATH

1-PLACE OF DEATH Provident Hospital + 101

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1514 Division ST. 14-20 WARD)

2-FULL NAME Thomas Walker

(a) RESIDENCE No. 818 S St. Paul St. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer 040

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Sarah Mathews (Address) 818 S. Paul St.

15 Filed 6 1929 . 19 H. MASON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 6 1929

17 I HEREBY CERTIFY, That I attended deceased from Apr 3 . 1929 . to Apr 6 . 1929 . that I last saw him alive on Apr 6 . 1929 . and that death occurred, on the date stated above, at 2.40 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Pericarditis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Undetermined

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C. F. Jackson M. D.

4/6 1929 (Address) Prov. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Va

DATE OF BURIAL Apr 7 1929

20 UNDERTAKER Jno. W. Chase Son

ADDRESS 1405 Madison

Spec.—2-29-28—L. F. S.—500 Blks.

E 44797 HEALTH DEPARTMENT—CITY OF BALTIMORE 31 E 44797

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 537 E. 38th ST., 947 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna Mary Heller

(a) RESIDENCE NO. 537 E. 38th ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 24, 1908

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
20	7	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stenographer

(b) General nature of industry, business, or establishment in which employed (or employer) Com. Office

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Ovide K. Heller

11 BIRTHPLACE OF FATHER (city or town) Philadelphia
(State or country) Pa.

12 MAIDEN NAME OF MOTHER Anna M Kenny

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant Ovide K Heller
(Address) 537 E. 38th St.

15 Filed 6-1929, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Thursday April 4, 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 8, 1928, to March 27, 1929,

that I last saw h[illegible] alive on March 27, 1929

and that death occurred, on the date stated above, at 2 10 P m.

The CAUSE OF DEATH* was as follows:—

Pulmonary Tuberculosis
(Tuberculosis of Lungs)

(duration) 4 yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Do not know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination of Sputum

(Signed) Anna S. Bergmann, M. D.

, 19 (Address) 3524 Greenmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	Apr 6 1929
20 UNDERTAKER	ADDRESS
Hughes & Jones Inc	4 & N Bdy

Spec.—1-10-21—M&T—1500 Bks.

E 44798

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44798

CERTIFICATE OF DEATH.

1-PLACE OF DEATH (2669)

CITY OF BALTIMORE: (No. 2669 Pa. Ave ST. 13-59 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jr Roy Singenfelder

(a) RESIDENCE NO. (2669) 2669 Pa. Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 5th 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 20 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER Christopher Singenfelder

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Lillian Augusta Poulsen

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Lillian A. Singenfelder

(Address) 2669 Pa. Ave

15 Filed APR 5 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5th 1929

17 I HEREBY CERTIFY, That I attended deceased from April 5th, 1929, to April 5th, 1929, that I last saw h alive on April 5, 1929, and that death occurred, on the date stated above, at 1:45 A. m.

The CAUSE OF DEATH* was as follows:

Asphyxia Neonatorum (following Breech delivery)

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? usual

(Signed) Edw C. Rulz M. D.

, 19 (Address) 2727 N. Fulton Ave Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health

ADDRESS

APR 5 - 1929

Rev. Ord. A. 1923

Spec. -7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44799

E 44799

CERTIFICATE OF DEATH

1929

1-PLACE OF DEATH aged Home

REGISTERED NO.

City of BALTIMORE: (No. 400 N. Fulton Ave Ward 20-17

(if death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Watkins

(a) RESIDENCE NO. 400 N. Fulton Ave Ward

(Usual place of abode)

Length of residence in city or town where death occurred 90 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Sept 18 1838

7 AGE — Years: 90 Months: 6 Days: 16 IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER Nicholas Watkins

11 BIRTHPLACE OF FATHER (City or town) Baltimore Md

(State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Beckam

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Pennsylvania

14 Informant Mrs. Goldsby

(Address) 400 N Fulton Ave

15 Filed APR 7 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 4 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 24 1929 to Apr 4, 1929.

that I last saw her alive on Apr 3, 1929.

and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Geo E. Shannon, M. D.

1929 (Address) 700 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet Date of Burial Apr 6 1929

20 UNDERTAKER Geo E Smith ADDRESS 113 Haldno

very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

Fannie Perrigo

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44800

CERTIFICATE OF DEATH

E 44800

1-PLACE OF DEATH Aged Home

REGISTERED NO.

City of BALTIMORE: (No. 400 N. Fulton Ave Ward 20-27)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Perrigo

(a) RESIDENCE NO. 400 N. Fulton Ave, Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 16 1844

7 AGE: Years 84 Months 11 Days 19

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Robert Smiley

11 BIRTHPLACE OF FATHER (City or town) (State or country) Delaware

12 MAIDEN NAME OF MOTHER Margaret Flood

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Etta Geddes

(Address) 400 N Fulton Ave

15 Filed 1929 C. HAMPSON JONES 16 Registrar RKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 5 1929

17 I HEREBY CERTIFY, That I attended deceased from Mar 2 1929 to Apr 5 1929 that I last saw her alive on Apr 3 1929 and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Nephritis.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No. Date of ✓

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) George E. Shannon, M. D.

Apr 5 1929 (Address) 700 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Olivet Date of Burial Apr 6 1929

20 UNDERTAKER: George E. Smith ADDRESS 453 L Hollins

very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44801

CERTIFICATE OF DEATH.

E 44801

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St. 14-20 WARD)

REGISTERED NO. 38

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Livers.

(a) RESIDENCE NO. 1538 Division ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	colored	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
				9

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Steven Joy Livers.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Charles Co. Md.

12 MAIDEN NAME OF MOTHER Roselie Davenport

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Norfolk Va

14 Informant
(Address)

15 [illegible] 19 CAMPION JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 2 1929

17 I HEREBY CERTIFY, That I attended deceased from April 2, 1929, to April 2, 1929, that I last saw him alive on April 2, 1929, and that death occurred, on the date stated above, at 1.05 P m.

The CAUSE OF DEATH* was as follows:

Congenital Lues.

(duration) yrs. mos ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Personal Exam.

(Signed) Sub H. Douglass, M. D.

(Address) Municipal Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health,

ADDRESS

APR 5 - 1929

UNIVERSITY OF MARYLAND

Spec.—12-9-25—A Co.—200 Bks.

E 44802

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 44802

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Church Home + Infirmary

City of BALTIMORE: (No. Broadway + Jaimore St.) (Ward) 6-9

2-FULL NAME Mrs. Elizabeth Nicklin

(a) RESIDENCE NO. 829 Pennsylvania Ave. Trenton, N. J. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Femal

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of Mr. Arthur Nicklin

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) England

PARENTS

10 NAME OF FATHER Mcd Mbolth

11 BIRTHPLACE OF FATHER (city or town)

(State or country) England

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) England

14 Informant Arthur Nicklin

(Address)

15 Filed ..... 19 HAMPSON JONES, M. D. Registrar

1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6, 1929 19

17 I HEREBY CERTIFY, That I attended deceased from March 5, 1929, to April 6, 1929

that I last saw her alive on April 6, 1929

and that death occurred, on the date stated above, at 8:45 a.m.

The CAUSE OF DEATH* was as follows:

Colitis

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? yes Date of March 27, 1929

Was there an autopsy? no Drainage

What test confirmed diagnosis?

(Signed) Walter B. Jefferson, M. D.

, 19 (Address) Church Home + Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Trenton N. J. Date of Burial 4/6 1929

20 UNDERTAKER: Louis Heinamann ADDRESS 32 S. Broadway

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44803

CERTIFICATE OF DEATH

117

E 44803

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. St Bat Hosp ST. 12-19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Julia Redmond

(a) RESIDENCE NO. 220 E Lafayette Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Redmond

6 DATE OF BIRTH (month, day, and year) March 1870

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
59.	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Strocker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Elizabeth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. M. C. Smith

(Address) 220 E. Lafayette Ave

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/6/29

17 I HEREBY CERTIFY, That I attended deceased from 4/4, 1929, to 4/6, 1929, that I last saw h alive on 4/6/29, 1929 and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Uremia

Partial (duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Intestinal obstruction

Unknown. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? Yes Date of 4/4/29

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Kathleen Watkins, M. D.

, 19 (Address) St Bath Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cem	Apr. 9 1929
20 UNDERTAKER	ADDRESS
Easton Sons & Elliott	

C. HAWKINS JONES M

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44804 — CERTIFICATE OF DEATH — 129 — E 44804

E 44804

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital Lombard & Greene ST.) (WARD)

REGISTERED NO. 15-63

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles J Sharer

(a) RESIDENCE NO. 3904 W. Garrison Blvd ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Cora E Sharer

6 DATE OF BIRTH (month, day, and year) April 13. 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	11	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Piano Repairer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Manchester, Md
(State or country)

PARENTS

10 NAME OF FATHER Jacob Sharer

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Margaret Yellough

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Edward C Sharer

(Address) Hampstead Md

PRT - 1125 C. HAMPSON JONES, M. D.
Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-6-29

17 I HEREBY CERTIFY, That I attended deceased from April 5th, 1929, to April 6th, 1929

that I last saw him alive on April 6th, 1929

and that death occurred, on the date stated above, at 5-40 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis
Uremia.

(duration) 1 yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood chemistry

(Signed) W C Swoope, M. D.

, 19 (Address) University Hospital Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	Apr 9 1929
20 UNDERTAKER	ADDRESS
H. J. Tschan & Sons	Md

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44805

CERTIFICATE OF DEATH

E 44805

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Md Genl Hospital ST. (WARD) 24

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME H. Griffith Davis

(a) RESIDENCE NO. Fowblesburg Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 4-1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	7	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Own business

9 BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER H. H. Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Edna E. Griffith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

PARENTS

14 Informant Edna Griffith

(Address) Hampstead Md

R 2-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-6-29

17 I HEREBY CERTIFY, That I attended deceased from 3-27, 1929, to 4-6-, 1929, that I last saw him alive on 4-6-, 1929, and that death occurred, on the date stated above, at 8[17] P m.

The CAUSE OF DEATH* was as follows:

Acute Cholecystitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation about 15 min

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? Yes Date of Mar 28-29

Was there an autopsy? Not

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

19 Address [illegible]

4/6/29 Md Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Grove Cem	4-9-1929

20 UNDERTAKER Wm J Trekner & Sons ADDRESS North & Penna Ave

Cor.—10-10-29—A Co.—100 Bks.

E 44806

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 44806

REGISTERED NO. 188-001

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) B & O R.R. Yard Locust Point St., 43-59 Ward

2-FULL NAME Barney Spector

(a) RESIDENCE NO. 3570 Auchentorly Terrace St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (Write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 10 – 1895

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	33	11	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Brakeman
(b) General nature of industry, business, or establishment in which employed (or employer) B.O.R.R.
(c) Name of employer

9 BIRTHPLACE (city or town) Brooklyn N.Y.
(State or country)

PARENTS

10 NAME OF FATHER Frank Spector

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Bertha Moravitz

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant S. Spector
(Address) 4425 Liberty St.

15 Filed ..... 19.. H. HAMPSON JONES, M. D.
Per ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) October 25 – 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

R.R. Acc

Multiple Fractures

Shock

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

10/26/29 (Signed) H. Gladden, M. D.

19 (Address) 143 N. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem

DATE OF BURIAL 10/31 1929

20 UNDERTAKER Jack Levin

ADDRESS 1439 E. Baltimore St

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Smullian

HEALTH DEPARTMENT—CITY OF BALTIMORE.

E 44807

CERTIFICATE OF DEATH.

25-001

E 44807

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1822 Smallwood pl. (St.) 15-68 (Ward)

2-FULL NAME Mrs. Rebecca Smullian

(a) RESIDENCE. No. 1822 Smallwood pl (Usual place of abode) WARD.

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William.

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Baer Jacobson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rachel Lindy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Mrs Eisenberg (Address) 1822 Smallwood Pl

15 Filed APR 7 - 1929 19 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 1929

17 I HEREBY CERTIFY, That I attended deceased from April 1st, 1929, to April 6th, 1929, that I last saw h[er] alive on April 6th, 1929, and that death occurred, on the date stated above, at 12.22 P. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia (left); Acute cardiac dilatation; Hypertension

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical findings

(Signed) Mitchell A Abrams, M. D.

4-6, 1929 (Address) 1360 Eutaw place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Herring Run — DATE OF BURIAL: 4/7 1929

20 UNDERTAKER: A. L. Swanson & Bro — ADDRESS 1127 E Balto st

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44808

CERTIFICATE OF DEATH

169 E 44808

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Found floating in the water at the

City of Baltimore: (No. foot of Riverside Ave & York St., 18-27 Ward)

2-FULL NAME Charles W. E. Wagner.

(a) RESIDENCE NO. 108 S. Scott St. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 49 yrs. 10 mos. 27 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White.	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Marie Wagner.

6 DATE OF BIRTH (month, day, and year) May 24, 1879

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	49	10	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cutter.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer 0 $0

9 BIRTHPLACE (city or town)
(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Charles F. Wagner

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore, Md

12 MAIDEN NAME OF MOTHER Emma Wittendorf.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) York Pa.

14 Informant Marie Wagner. (wife)
(Address) 108 S. Scott st.

15 Filed [illegible] 19 HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Missing March 23, Body found April 5, 192[illegible]

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide by Drowning.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? —o.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Police Report.

(Signed) M. D.

4/6, 192a (Address) 1017 N. Charles st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery. DATE OF BURIAL April 8 - 1924

20 UNDERTAKER J. Cowan & Son. ADDRESS 901 Cathedral St.

Spec.—2-29-28—L. F. S.—500 Blks.

Dee

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44809

CERTIFICATE OF DEATH

90

E 44809

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 628 Brice St. ST. 16-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ellen T. Dee

(a) RESIDENCE NO. 628 Brice St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if fnreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: late John J. Dee

6 DATE OF BIRTH (month, day, and year): June 8th. 1870

7 AGE: Years 58; Months 9; Days 28 1; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 0 21

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

10 NAME OF FATHER: John Enright

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Johanna O'Donnell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

Informant: Mr. Thos. I. Dee

(Address): 4620 Park Hghts. Ave.

Filed 4-1929, 19

HARRISON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 5 1929

17 I HEREBY CERTIFY, That I attended deceased from April 5, 19 29, to April 5, 19 29, that I last saw h alive nn April 5, 19 29 and that death occurred, on the date stated above, at 7.30 A. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis 3 Yrs.

Chronic Endocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Cerebral Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease cnntracted if not at place of death?

Did an operation precede death? Date of

Was there an autnpsy?

What test confirmed diagnosis? Clinical

(Signed) Edw Kendall M. D.

4/6, 19 29. (Address) 24 W. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: Apr. 8 19 29

20 UNDERTAKER: J. J. Govan & Son — ADDRESS: 501 Holins St.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44810 — CERTIFICATE OF DEATH — 3 — E 44810

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) 2547 Hollins St. (WARD) 20-69

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John C Wiegand

(a) RESIDENCE NO. (Usual place of abode) 2547 Hollins ST., WARD

Length of residence in city or town where death occurred 61 yrs. 6 mos. 15 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 21st 1867.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	6	15 14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Once worked for City

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

10 NAME OF FATHER Peter Wiegand

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Francis Isell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Miss Rose M Wiegand

(Address) 2547 Hollins St

Filed APR 7 1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 5th 1929.

17 I HEREBY CERTIFY, That I attended deceased from 1/24/29, 19 to 4/5/29, 19, that I last saw h[illegible] alive on 4/4/29, 19, and that death occurred, on the date stated above, at 6A. m.

The CAUSE OF DEATH* was as follows:

Arthenia

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) [signature], M. D.

4/6/29 (Address) 375 S Wash

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem — DATE OF BURIAL: Apr 8th 1929.

20 UNDERTAKER: J. C. Cowan & Son — ADDRESS: 901 Hollins

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44811

CERTIFICATE OF DEATH

E 44811

1—PLACE OF DEATH

REGISTERED NO. 1668

CITY OF BALTIMORE: (No. 215 Calverton Heights ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Katherine E. Schwemmer

(a) RESIDENCE NO. 215 Calverton Heights ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: John F. Schwemmer

6 DATE OF BIRTH (month, day, and year): Feb. 23-1866

7 AGE: Years 63 | Months 1 | Days 12. | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home Duties

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: 0?

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

10 NAME OF FATHER: Dont Know.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Dora Waldeck

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

Informant: Frank F. Schwemmer Jr.

(Address) 215 Calverton Heights

Filed 1-7-1929 C. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 7 29

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1928, to Apr. 7, 1929,

that I last saw h alive on 4/4 -, 1929

and that death occurred, on the date stated above, at 2.30 p.m.

The CAUSE OF DEATH* was as follows:

General arteriosclerosis

Appendicitis (abscess)

Operation. 12-26-28

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 12-26-28

Was there an autopsy? Yes

What test confirmed diagnosis? Phy Examination

(Signed) W. J. Rosario, M. D.

4/4. 1929 (Address) 804 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: apr 8. 1929

20 UNDERTAKER: Mrs. Mrs. John H. Weyler & Son

ADDRESS: 5 N. Eutaw St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44812

CERTIFICATE OF DEATH

112

E 44812
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 702 Dryden Drive 11-66 Ward)

2-FULL NAME Louis J Batzler

(a) RESIDENCE NO. 702 Dryden Drive Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Laura J Batzler

6 DATE OF BIRTH (month, day and year): Oct 10-1865

7 AGE: Years 63 | Months 5 | Days 27 | IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Merchant
(b) General nature of industry, business, or establishment in which employed (or employer): Chemical Business
(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore
(State or country)

PARENTS

10 NAME OF FATHER: John L. Batzler

11 BIRTHPLACE OF FATHER (city or town): Germany
(State or country)

12 MAIDEN NAME OF MOTHER: Margaretta Hirshberg

13 BIRTHPLACE OF MOTHER: Germany
(State or country)

14 Informant (Address): Laura Batzler

15 Filed 11-1-1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): Oct 26 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Error of diet

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. Leander Blank, M. D.

Oct 26 1929 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: Nov 1 1929

20 UNDERTAKER: Mr-Mrs. John N. Teufel & Son — ADDRESS: 801 N. Fayette

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44813

CERTIFICATE OF DEATH

31

E 44813

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 842 N. 34th ST. 13-5 (WARD)

2—FULL NAME Mary Jessie Somerville

(a) RESIDENCE NO. 842 N. 34st ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Nov. 17/1889

AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
39.	4	14.	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work.

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer at home.

BIRTHPLACE (city or town) (State or country) Balto city Md.

10 NAME OF FATHER James A Somerville

11 BIRTHPLACE OF FATHER (city or town) (State or country) England.

12 MAIDEN NAME OF MOTHER Julia E. Downey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto city Md.

Informant Julia E. Somerville

(Address) 842 N. 34 St.

Filed APR 7 - 1929 C. HUBERT BOYD, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6/29.

17 I HEREBY CERTIFY, That I attended deceased from Feb 22, 1929, to April 6, 1929, that I last saw her alive on April 5 1929 and that death occurred, on the date stated above, at 955 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary & Ontestinal Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) W. H. Smith, M. D.

April 6, 1929 (Address) 3429 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem. DATE OF BURIAL April 9 1929

20 UNDERTAKER Hall & Davis ADDRESS 330 Paine St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 44814

1—PLACE OF DEATH

REGISTERED NO. E 44814

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 218 N. Shroeder ST. 18-N WARD)

2—FULL NAME Susie O Easton

(a) RESIDENCE NO. 218 N. Shroeder St ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1881

7 AGE: Years 48 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Don't know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Don't know

12 MAIDEN NAME OF MOTHER: Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Don't know

14 Informant: Wm O Boyer

(Address) 622 Gilbert St

15 Filed APR 7 - 1929

C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/6/29.

17 I HEREBY CERTIFY, That I attended deceased from Jan 16th, 1929, to April 6th, 1929, that I last saw her alive on 4/2, 1929 and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis.

(duration) yrs. 3 mos. 20 ds.

CONTRIBUTORY (Secondary): Pyorrhea Infection

(duration) yrs. 3 mos. 20 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Examination

(Signed) C. C. Lunn, M. D.

4/6, 1929 (Address) 622 N. Arlington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: 4-7-1929

20 UNDERTAKER: Daniel Easton

ADDRESS 916 Baltimore

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT CITY OF BALTIMORE

E 44815

CERTIFICATE OF DEATH

E 44815

1-PLACE OF DEATH

REGISTERED NO. 186-103

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of Baltimore: (No. 1527 McCulloh St. 11-20 Ward)

2-FULL NAME Charles Doles

(a) RESIDENCE NO. 1527 McCulloh St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida Doles.

6 DATE OF BIRTH (month, day, and year) Nov 4 1872

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
56	5	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Interior Decorator
(b) General nature of industry, business, or establishment in which employed (or employer) For Self
(c) Name of employer

9 BIRTHPLACE (city or town) N. C.
(State or country)

PARENTS

10 NAME OF FATHER Jos. Doles

11 BIRTHPLACE OF FATHER (city or town) N. C.
(State or country)

12 MAIDEN NAME OF MOTHER Eliza —

13 BIRTHPLACE OF MOTHER (city or town) N. C.
(State or country)

14 Informant Ida Doles
(Address) 1527 McCulloh

15 Filed ..... 19..... Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2nd 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Automobile Accident

Cerebral Hemorrhage

(duration) yrs. Instantaneous

CONTRIBUTORY (Secondary) Concussion of Brain. Contusion of Head & Eye. Abrasion of Face. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Druid Hill Ave

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Regular

(Signed) T. C. Lunk, M. D.

May 4th 1929 (Address) Coroner.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 4-7-1929

20 UNDERTAKER Samuel Easton

ADDRESS 46 Oa ave

Important: See instructions on back of certificate.

HAMPSON JONES, M. D.

Spec.—2-29-28—L. F. S.—500 Bks.

44816

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 44816

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE: (No. [redacted] ST., 17-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thomas Jackson

(a) RESIDENCE NO. 527 Lambert ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) D40

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland (State or country)

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records of BALTIMORE CITY HOSPITALS

(Address) HAMPSON JONES, M. D.

15 Filed [illegible], 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 30, 29 to April 4, 29

that I last saw him alive on April 4, 29

and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) John E. Moran, M. D.

, 19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	4-7 1929
20 UNDERTAKER	ADDRESS 916 Eo ave
Daniel Easton	

Spec.—2-29-28—L. F. S.—500 Bks.

E 44817

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

47

E 44817

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 1212 Belvedere Ave ST.) 27-54 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary I. Swem

(a) RESIDENCE NO. 1212 Belvedere Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6a If married, widowed, or divorced BUSBAND of (or) WIFE of: George R. Swem

6 DATE OF BIRTH (month, day, and year): June 4-1856

7 AGE — Years: 72 | Months: 10 | Days: 1 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Co. Md.

10 NAME OF FATHER: Geo. Frederick Walters

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary Amelia Rick

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Mrs. Bessie M. Swem

(Address): 1212 Belvedere Ave

15 Filed 7-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 5 1929

17 I HEREBY CERTIFY, That I attended deceased from March 17th, 1929, to April 4th, 1929, that I last saw her alive on April 4th, 1929 and that death occurred, on the date stated above, at 2 15 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Right Breast

Probably 3 years (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Personal Observation

(Signed) Wm Lowell Fole, M. D.

, 19 (Address) 1900 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge — DATE OF BURIAL: April 8 19 29.

20 UNDERTAKER: Horace F. Burgee — ADDRESS: 3631 Falls Road

Spec.—2-29-28—L. F. S.—500 Bks.

E 44818

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001

E 44818

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE; (No. 5 Irvine Place ST. 6-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Brina Friedman

(a) RESIDENCE NO. 5 Irvine Place ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Jacob Friedman

6 DATE OF BIRTH (month, day, and year): 1859

7 AGE: Years 70 | Months — | Days — | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 031

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant ... (Address) 1439 E Balto

15 Filed 1929. C. HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 7, 1929.

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1929. to April 7, 1929.

that I last saw her alive on April 7, 1929.

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Samuel B Wolfe, M. D.

4/7, 1929 (Address) 1331 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel — DATE OF BURIAL: 4-7-1929

20 UNDERTAKER: Jack Lewis, 1439 E Balto. — ADDRESS

Spec.—1-12-23—M&T—500 Blks.

E 44819

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 44819
REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 29 S Stricker ST. 14-28 WARD)

2-FULL NAME Joseph Karaskewicus Or Karas

(a) RESIDENCE No. 29 S Stricker ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. ds. How long in U. S., If of foreign birth? 30 yrs. — mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) No 1879

7 AGE 50 Years — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Talor

(b) General nature of industry, business, or establishment in which employed (or employer) 0$0

(c) Name of employer Grif

9 BIRTHPLACE (city or town) (State or country) Lithvaina

PARENTS

10 NAME OF FATHER Kaitonas Karaskewicus

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithvania

12 MAIDEN NAME OF MOTHER Nastazia Kubil

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithvania

14 Informant Josephin Karaskewicus
(Address) 29 S Stricker St.

15 Filed 4-7-1928 By HAMPSON JONES, M. D. Registrar
Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4 — 5 1928

17 I HEREBY CERTIFY, That I attended deceased from Mch 20, 1928, to April 5, 1928, that I last saw h[illegible] alive on April 5, 1928, and that death occurred, on the date stated above, at 3 30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

18 Was there an autopsy? no

What test confirmed diagnosis? [illegible]

(Signed) [illegible] M. D.

4/6, 1928 (Address) 571 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	March 8. 1929
20 UNDERTAKER	ADDRESS
John Grebliauckas	425 S Pace St.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44820 38 E 44820

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Rennert Hotel ST. 425 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Thomas Knight

(a) RESIDENCE NO. Hotel Rennert ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 64 yrs. 7 mos. 3 ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillie Knight

DATE OF BIRTH (month, day, and year) Sept 2 1865

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
~~63~~	64	7	3	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real Estate Broker

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer —

BIRTHPLACE (city or town) Baltimore Co
(State or country) Maryland

10 NAME OF FATHER James Oliver Knight

11 BIRTHPLACE OF FATHER (city or town) Balto Co
(State or country)

12 MAIDEN NAME OF MOTHER Helena Stanley

13 BIRTHPLACE OF MOTHER (city or town) Phila
(State or country) Pa.

Informant W H Sunnott

(Address) 2N Stevington St

APR 7 - 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5 1929.

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1928. to April 5 1929.

that I last saw h. alive on April 6 1929

and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Compression thoracic aorta to my knowledge 3 y cals

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical & X Ray

(Signed) K. L. Keyser, M. D.

4/6, 1929 (Address) Westworth apts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet	4/8/29
20 UNDERTAKER Henry H. Jenkins Sons Co	ADDRESS McCulloh & Orchard Sts.

Spec.—1-10-21—M&T—1500 Bks.

E 44821

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 E 44821

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Women's Hospital 11-15 ST. (WARD)

2-FULL NAME Miss Elizabeth S. Lockwood

(a) RESIDENCE No. 8 E. Eager St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 8, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
69		8	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Co; (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm T. Lockwood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Vermont

12 MAIDEN NAME OF MOTHER Elizabeth Greene

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Maryland

14 Informant Miss Virginia Lockwood (Address) 8 E. Eager St

15 Filed APR 7 - 1929 HAMPSON LONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 1928, to April 6, 1929, that I last saw h alive on April 6, 1929, and that death occurred, on the date stated above, at 9:36 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma - meningitis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Carcinoma of Vertebrae

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Lamb B Hamilton M. D.

4/6, 1929 (Address) 2602 Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL, Garrison Forest & Thomas con

DATE OF BURIAL April 8, 1929

20 UNDERTAKER Henry Heuking Sons & Co

ADDRESS Oakland Md

Spec.—2-29-28—L. F. S.—500 Bks.

E 44822

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

24-001

E 44822

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1508 W. Lexington ST. 14-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles H. Curley

(a) RESIDENCE NO. 1508 W. Lexington ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 78 yrs. 0 mos. 15 ds. How long in U. S., If foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret R. Curley

7 DATE OF BIRTH (month, day, and year) Oct 20 1850

AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	78	0	15	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stationer & Printer

(b) General nature of industry, business, or establishment in which employed (or employer): 63

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Baltimore Md

10 NAME OF FATHER: William Curley

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: Mary E. Carr

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

Informant: Margaret R. Curley

(Address) 1508 W. Lexington

Filed 4-7-1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 5 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 19 1929 to age 5 1929.

that I last saw him alive on age 5 1929

and that death occurred, on the date stated above, at 11 15 A m.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary): Arteriosclerosis.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Edgar Innes M. D.

19 (Address) 1500 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	April 8 1929

20 UNDERTAKER: Chas. J. Black ADDRESS: 742 W. Northern

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44823

CERTIFICATE OF DEATH

117 E 44823

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 813 N. Calhoun ST. 16-23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Irene Virginia Branch

(a) RESIDENCE NO. 813 N. Calhoun ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs. 6 mos. 18 ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept., 14, 1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23	6	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

10 NAME OF FATHER Lonnie Branch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Raleigh N.C.

12 MAIDEN NAME OF MOTHER Nellie Collier

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Richmond Va.

Informant Milton E. Branch

(Address) 321 N. Mount St.

APR 7 - 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 7, 1929 to April 4, 1929,

that I last saw her alive on April 4, 1929

and that death occurred, on the date stated above, at 5:30 p. m.

The CAUSE OF DEATH* was as follows:

Acute Peritonitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Appendecitis (Ruptured)

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical exam.

(Signed) Walter J. Jackson, M. D.

, 19 (Address) 1651 W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Lire	April 8 1929
UNDERTAKER	ADDRESS
Joseph A. Lively	409 N Mount St

Spec.—2-29-28—L. F. S.—500 Bks.

E 44824

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 44824

1—PLACE OF DEATH

REGISTERED NO. 16-37

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Addie Peck

(a) RESIDENCE NO. 769 Linmore St. ST., Richmond Va WARD W. T. B.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	widow

a If married, widowed, or divorced HUSBAND of (or) WIFE of Alexander Peck

DATE OF BIRTH (month, day, and year) Aug 17 1876

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
52		7	20	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Virginia (Richmond)

10 NAME OF FATHER Taylor Unknown Blackburn

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

Informant Hospital Records

(Address)

Filed 4-7- 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7, 1929

17

I HEREBY CERTIFY, That I attended deceased from Jan. 14, 19 29, to 4-7-, 19 29,

that I last saw h e alive on 4-7-29, 19

and that death occurred, on the date stated above, at 7:15 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Positive Sputum

(Signed) Harry E. Smith M. D.

4-7, 19 29 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Richmond Va	4/7/29

20 UNDERTAKER Harry Weditzke ADDRESS 1531 W Lombard St

Spec.—2-29-28—L. F. S.—500 Bks.

E 44825

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 44825

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 907 Fell ST. 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME MARY JOHNSON

(a) RESIDENCE NO. 907 Fell ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 86 yrs. mos. ds. How long in U. S., if foreign birth? 86 yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew Johnson

6 DATE OF BIRTH (month, day, and year) July 22, 1840

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	88	8	14	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER John Grauling

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

Informant Mr. Andrew Johnson (Husband)

(Address) 907 Fell Street

Filed 1929 C. HAMPSON JONES, M. D. Registrar

By Robt

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5, 1929

17 I HEREBY CERTIFY, That I attended deceased from 3/29, 19 29, to 4/5, 19 29

that I last saw her alive on 4/5, 19 29

and that death occurred, on the date stated above, at 3.30 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral sclerosis, cardiac regurgitation

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia, Heart failure

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & symptoms

(Signed) Jay D. Baldwin, M. D.

19 (Address) 1623 E Baltimore.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cemetery

DATE OF BURIAL Apr. 8, 1929

20 UNDERTAKER Henry Sander & Sons, Inc.

ADDRESS BALTIMORE ST. & BROADWAY.

Spec.—2-29-28—L. F. S.—500 Bks.

E 44826. ✓ E 44826.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129

REGISTERED NO. E 44826

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 403 S. Anglesea ST. (WARD) 16-37

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank Stibor.

(a) RESIDENCE NO. 403 S. Anglesea ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Stibor

6 DATE OF BIRTH (month, day, and year) Jan 1853

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	2 3	—	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Musician

(b) General nature of industry, business, or establishment in which employed (or employer) 656

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Bohemia

10 NAME OF FATHER dont know

11 BIRTHPLACE OF FATHER (city or town) (State or country) dont know

12 MAIDEN NAME OF MOTHER dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) dont know

Informant Joseph F. Vitko

(Address) 967 N. Chester St

Filed APR 7 - 19

C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5-1929

17 I HEREBY CERTIFY, That I attended deceased from April, 1928, to April 5, 1929

that I last saw h/m alive on April 4, 1929

and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Chronic Myocarditis

arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) T. Joseph Donlan, M. D.

, 19 (Address) 800 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oakhill Cemetery — DATE OF BURIAL April 8 1929

UNDERTAKER George W. Zickler — ADDRESS 1737 E. Eager St.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

44821

90 E 44827

E 44827

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 206 E. 31st ST. 9-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rebecca M. Ward

(a) RESIDENCE NO. 206 E. 31st ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) Feb. 14, 1847

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	1	22 21	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

10 NAME OF FATHER John Ward

11 BIRTHPLACE OF FATHER (city or town)
(State or country) England

12 MAIDEN NAME OF MOTHER Eliz J. Gibson

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mrs. Wm. B. Wheeler
(Address) 206 Southway, Guilford

15 Filed C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 1. 29, to Apl. 5. 29,
that I last saw her alive on Apl. 5. 29
and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

old age.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Hubert C Blake, M. D.

4 6, 1929 (Address) Medical Arts. Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Apr. 8 1929
20 UNDERTAKER Leppold & Co.	ADDRESS 1002 West Baltimore St.

RT - 1929

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44828

CERTIFICATE OF DEATH

31 V 44828

E 44828

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1025 W. Baltimore ST. 18-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edward V. Kipe

(a) RESIDENCE NO. 1025 W. Baltimore ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Ada Kipe

DATE OF BIRTH (month, day, and year) Sept. 26, 1889

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	6	11	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Baltimore & Ohio R.R.

BIRTHPLACE (city or town) (State or country) Washington County Maryland

10 NAME OF FATHER Harry M. Kipe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Etta Rice

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Etta Kipe

(Address) 1025 W. Baltimore St.

15 Filed 1929, THOMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6, 1929

17 I HEREBY CERTIFY, That I attended deceased from Apr. 4, 1929, to Apr. 6, 1929, that I last saw him alive on Apr. 6, 1929, and that death occurred, on the date stated above, at 1.55A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) None.

(duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam Etc.

(Signed) Chas Norton, M. D.

4/7, 1929 (Address) 885 W. Lombard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Knoxville, Md.

DATE OF BURIAL April 9" 1929

20 UNDERTAKER Joseph B. Cook

ADDRESS 1009 West Baltimore St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44829

CERTIFICATE OF DEATH

74-001

E 44829

REGISTERED NO.

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE: (No. ST. 6-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Susan Ford

(a) RESIDENCE NO. 1926 Baltimore ST. (East) WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. ? mos. ? ds. How long in U. S., if foreign birth? — yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: ?

6 DATE OF BIRTH (month, day, and year): ? 1865

7 AGE: Years 64 | Months ? | Days ? | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town): ?

(State or country): N.C.

10 NAME OF FATHER: ?

11 BIRTHPLACE OF FATHER (city or town): ?

(State or country): ?

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town): ?

(State or country): ?

14 Informant .....

(Address) .....

15 Filed 7-1929, 19 ..... HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-6-29

17 I HEREBY CERTIFY, That I attended deceased from 4-5, 1929, to 4-6, 19 9, that I last saw her alive on 4-6, 19 9, and that death occurred, on the date stated above, at 7.30 ? m.

The CAUSE OF DEATH* was as follows:

Hemorrhage into Cerebrum, Left, with Rt Hemiplegia

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary): None

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam

(Signed) Marvin M. McLean M. D.

, 19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Enfield Halifax Co. N. Carolina

DATE OF BURIAL: April 8 1929

20 UNDERTAKER: H. Sander Sons

ADDRESS: 1710 E. Lee St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

227 E 82 44830

CERTIFICATE OF DEATH

× 90 ✓

E 44830

1—PLACE OF DEATH Johns Hopkins Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 7-9 WARD)

2—FULL NAME Dr. James C. Braswell

(a) RESIDENCE NO. Whiteville, N. C. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Louise Braswell

DATE OF BIRTH (month, day, and year): Jan 22/1859

AGE: Years 70 Months 2 Days 15 If LESS than 1 day, ... hrs. or ... min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Physician

(b) General nature of industry, business, or establishment in which employed (or employer): Dr

(c) Name of employer

BIRTHPLACE (city or town) (State or country): North Carolina

10 NAME OF FATHER: Eucheleus Braswell

11 BIRTHPLACE OF FATHER (city or town) (State or country): North Carolina

12 MAIDEN NAME OF MOTHER: Margaret Castelin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): North Carolina

Informant: Wife

(Address) Johns Hopkins Hospital

APR 7 - 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 7/29

17

I HEREBY CERTIFY, That I attended deceased from February 5, 1929 to April 7, 1929, that I last saw him alive on April 7, 1929 and that death occurred, on the date stated above, at 11 m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Benign Prostatic Hypertrophy (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of 2/9/29

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. C. Smith, M. D.

4/7, 1929 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Rock Mount N C

DATE OF BURIAL: 4/7 1929

UNDERTAKER: Wm Cook

ADDRESS: 1217 St Paul

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

527 797 **E 44831**

CERTIFICATE OF DEATH

E 44831

REGISTERED NO.

1—PLACE OF DEATH Johns Hopkins Hospital

CITY OF BALTIMORE: (No. ..... ST. 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Herman R. Baptiste

(a) RESIDENCE NO. Shareistown Pa ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. 2 mos. ..... ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Fanny

DATE OF BIRTH (month, day, and year) Unknown

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Life Insurance

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer 06

BIRTHPLACE (city or town) (State or country) Pa

10 NAME OF FATHER George W. Baptiste

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Helen Robertson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

Informant Friends

(Address) Johns Hopkins Hospital

FILED APR 7 - 1929 CHAMPION JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7/29

17

I HEREBY CERTIFY, That I attended deceased from Feb 24, 1929, to April 7, 1929, that I last saw h in alive on April 7, 1929 and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Septicaemia, Bacillus proteus.

(duration) ..... yrs. ..... mos. 5 ds.

CONTRIBUTORY (Secondary) Papillary Carcinoma of Bladder Resected yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Not Home

Did an operation precede death? yes Date of 2/27/29

Was there an autopsy? No

What test confirmed diagnosis? Operation.

(Signed) H. C. Smith, M. D.

4/7, 1929 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Walker Bare Pa

20 UNDERTAKER Wm Cook

DATE OF BURIAL 4/1 1929

ADDRESS 121 St Paul

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44832

CERTIFICATE OF DEATH

29 E 44832

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1442 Covington ST. 24-35 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Helen F. Cornell

(a) RESIDENCE NO. 1442 Covington ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

If married, widowed, or divorced
HUSBAND of Fred Cornell
(or) WIFE of

DATE OF BIRTH (month, day, and year) Feb 6, 1886

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	2		

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At home

BIRTHPLACE (city or town) (State or country) Baltimore Md

10 NAME OF FATHER Edmund Ringrose

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Isabella Tolley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Fred Cornell

(Address) 1442 Covington St

APR 8 - 1929

HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6. 1929

17

I HEREBY CERTIFY, That I attended deceased from June 15th, 1929, to April 6, 1929, that I last saw h[illegible] alive on April 6, 1929 and that death occurred, on the date stated above, at 2.30 A.M.

The CAUSE OF DEATH* was as follows:

Acute cardiac dilatation

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis with hypertension (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) Sidney F. Street, M. D.

4/7, 1929 (Address) 445 E Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet	4/10 1929
20 UNDERTAKER	ADDRESS
H. Cook	214 S. Broadway

Spec.—1-10-21—M&T—1500 Bks.

E 44833

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44833

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH Franklin Square Hospital

CITY OF BALTIMORE: (No. 11-15 St.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles ~~Gottnagel~~ Nothnagel

(a) RESIDENCE No. 1131 Brentwood Ave. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna E. Nothnagel

6 DATE OF BIRTH (month, day, and year): Sept 17, 1859

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
69	6	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: William Nothnagel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: William A. Nothnagel

(Address) 1131 Brentwood Ave

15 C. HAMILTON JONES, M. D.

APR 8 - 1929

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-5 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan. 19. 1929. to April 5 1929.

that I last saw h[illegible]ve on April 5th 1929.

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Hypertrophied Prostate

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(duration) yrs. 5 mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 4-5-29

Was there an autopsy? No

What test, confirmed diagnosis? Clinically

(Signed) C. W. Peake, M. D.

, 19 . (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL* St Mathews

DATE OF BURIAL 4 8 1929

20 UNDERTAKER W. H. Cook

ADDRESS 127 N. Gay St

Spec.—2-29-28—L. F. S.—500 Bks.

Dr Green, Hamilton Apr 6 Norfolk Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44834

CERTIFICATE OF DEATH

129 **E 44834**

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3413 Keene Ave ST. 27-43 WARD

2—FULL NAME Katie C Chapped

(a) RESIDENCE NO. 3413 Keene Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank M Chappel

6 DATE OF BIRTH (month, day, and year): Feb 8-1879

7 AGE — Years: 50 | Months: 1 | Days: 29 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind uf work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

10 NAME OF FATHER: Robt W Burgess

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mary A. Clarke

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Mansell. Chappel

(Address): 3413 Keene Ave

15 Filed 4-8-1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 6-1929

17 I HEREBY CERTIFY, That I attended deceased from Feby 4, 1929, to apr 6, 1929, that I last saw her alive on apr 5, 1929, and that death occurred, on the date stated above, at 11:00 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
(Uremic Coma)

a number of years
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Chronic Myocarditis
a number of years
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Morris B. Green, M. D.

4/7, 1929 (Address) Hamilton Baltimore Md

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery — DATE OF BURIAL: 4/8 1929

20 UNDERTAKER: Wyllie & Cooke — ADDRESS: 1211 Park Ave

Spec.—2-20-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44835

91-002

E 44835

CERTIFICATE OF DEATH

BALTIMORE CITY HOSPITALS

1—PLACE OF DEATH [redacted]

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 9-18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Long

(a) RESIDENCE NO. 2039 Aisquith ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? — yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jr J Long 1873

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) ? Md.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) ? Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ? Md.

14 Informant (Address) BALTIMORE CITY HOSPITALS

15 Filed R 8 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-6-29

17 I HEREBY CERTIFY, That I attended deceased from 3-27, 1929, to 4-6, 1929, that I last saw her alive on 4-6, 1929 and that death occurred, on the date stated above, at 2.30 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis & Hypertension

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) — yrs. mos. ds.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Chart

(Signed) Wilbur H. McLean, M. D.

, 19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet

DATE OF BURIAL 4 9 1929

20 UNDERTAKER J H Cook

ADDRESS 1219 Lombard

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44836

CERTIFICATE OF DEATH.

31

E 44836

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1320 Hollins St. 19-29 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Bartholow Buckingham

(a) RESIDENCE NO. 1320 Hollins St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 30-1862

7 AGE. Years	Months	Days 6	IF LESS than 1 day.....hrs. or.....min.
66	10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Produce.

(c) Name of employer —

9 BIRTHPLACE (city or town) Howard County

(State or country) Maryland.

PARENTS

10 NAME OF FATHER William D. Buckingham

11 BIRTHPLACE OF FATHER (city or town) Frederick Co

(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Mary A. Bartholow

13 BIRTHPLACE OF MOTHER (city or town) F'k Co

(State or country) Maryland.

14 Informant Elizabeth F. Buckingham

(Address) 1320 Hollins St.

8-1929 Filed C. H. JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6-1929.

17 I HEREBY CERTIFY, That I attended deceased from January 23 1929, to April 6- 1929; that I last saw him alive on April 4- 1929; and that death occurred, on the date stated above, at 3:15 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) none

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Sputum Test & Physical Signs

(Signed) Chester Roland, M. D.

4-6-1929 (Address) 2532 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet Cem Date of Burial 4/9 1929

20 UNDERTAKER Robert Brooks & Son ADDRESS Calhoun & Hollins

Spec.—2-29-28—L. F. S.—500 Blks.

E 44837

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001

E 44837

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 509 Hanover St. 12-30 WARD)

2—FULL NAME Jennie Campbell

(a) RESIDENCE NO. 509 Hanover ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married~~, Widowed, or Divorced, (write the word): Widow

a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Campbell

6 DATE OF BIRTH (month, day, and year): August [illegible]

7 AGE: 87 Years | Months C | Days C | If LESS than 1 day, hrs. or... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

PARENTS

14 Informant: Edward A. Riffle

(Address): Linthicum Heights Md

15 Filed ..... 19 ..... PATRICK JONES, M. D. Registrar

28-1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 6 1929

17 I HEREBY CERTIFY, That I attended deceased from ~~age~~ April 4, 1929, to ~~age~~ April 6, 1929, that I last saw ~~her~~ alive on ~~age~~ April 4, 1929 and that death occurred, on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

apoplexy

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Visual

(Signed) H. S. Smith, M. D.

(Address) 129 W. Lee St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem. | DATE OF BURIAL: April 8 1929

20 UNDERTAKER: Fos Forrest & Son | ADDRESS: 207 S. Pine

Spec.—2-29-28—L. F. S.—500 Bks.

E 44838 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 E 44838

CERTIFICATE OF DEATH

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

CITY OF BALTIMORE: (No. [redacted] ST. 21-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ann Martha Kaufman

(a) RESIDENCE NO. 73 Foundry Ct ? ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? — yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married ?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Kaufman ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) ? (State or country) Md.

10 NAME OF FATHER Wm Neal

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Md.

12 MAIDEN NAME OF MOTHER Maria Lewson

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Md.

PARENTS

14 Informant [redacted] (Address)

15 Filed [redacted] 19 Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-6-29

17 I HEREBY CERTIFY, That I attended deceased from ~~March 2~~ 2/ 19 29, to April 6, 19 29

that I last saw h[illegible] alive on 4-6, 19 29

and that death occurred, on the date stated above, at 5 00 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis & Hypertension ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Marvin M. M. Gross, M. D.

19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet Cemetery	April 8 1929
20 UNDERTAKER Jos Joerdens & Son	ADDRESS 2173 E. Pra[illegible]

APR 8 - 1929

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44839

CERTIFICATE OF DEATH

100-001

E 44839

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. So Balto Gen'l Hosp. ST., 21-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Wm Burton

(a) RESIDENCE NO. 1108 Ward ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 6 mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 12 1928

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	0	6	24 5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby

(b) General nature of industry, business, or establishment in which employed (or employer) ds

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Clarence Burton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Ella Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Clarence Burton

(Address) 1108 Ward st

15 Filed APR 8 1929 THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6, 1929

17

I HEREBY CERTIFY, That I attended deceased from 3/31, 19 29, to 4/6, 19 29

that I last saw h.. alive on 4/6/29, 19

and that death occurred, on the date stated above, at 7 15 p. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Unimportant

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. Katzenbach, M. D.

4/7, 19 29 (Address) 1st Balto Fr. 17-29.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western — DATE OF BURIAL April 8 1929

20 UNDERTAKER John Forde — ADDRESS 1200 W Fayette

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44840

CERTIFICATE OF DEATH.

1929 **E 44840**

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St. 25-7 Ward

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Milburn Miller

(a) RESIDENCE NO. 2313 Washington Boulevard Ward

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 30 1923

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	5	9	13	6

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ~~Master~~ None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Martin Miller

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore

12 MAIDEN NAME OF MOTHER Margaret Clark

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore

14 Informant Martin Miller

(Address) 2313 Washington Blvd

15 Filed APR 8 - 1929 HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/6 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Accidental Burns, clothing caught fire while playing in yard. 3rd degree burns

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Chas. A. Brooke M. D.

(Coroner)

4/6 1929 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Date of Burial 4/8 1929

20 UNDERTAKER John J. Fields ADDRESS 120 W Lombard

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44841
1—PLACE OF DEATH

CERTIFICATE OF DEATH

24-001

E 44841
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE; (No. 1609 Laurens St ST. 16-22 WARD)

2—FULL NAME Sarah Cohen

(a) RESIDENCE NO. 1609 Laurens St ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if foreign birth? 30 yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Morris Cohen

6 DATE OF BIRTH (month, day, and year): 1874

7 AGE — Years: 54 | Months: — | Days: — | If LESS than 1 day, ...hrs. or ....min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

10 NAME OF FATHER: Aaron Rammsky

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Mary

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Morris Cohen

(Address): 1609 Laurens St

15 4-8-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-8-29

17 I HEREBY CERTIFY, That I attended deceased from Apr 5, 1929, to Apr 7, 1929, that I last saw h[illegible] alive on Apr 7, 1929, and that death occurred, on the date stated above, at 1.30 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. L. Hornstein, M. D.

4/8, 1929 (Address) 733 Argyle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale — DATE OF BURIAL: 4/8 1929

20 UNDERTAKER: Jack Lewis 1439 E Balt — ADDRESS

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44842

CERTIFICATE OF DEATH

BALTIMORE CITY HOSPITALS

90 **E 44842**

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST., 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Smith

(a) RESIDENCE NO. 571 N Gay ST., ... WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., If foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

7 DATE OF BIRTH (month, day, and year) ?

8 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	87	—	—	

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) ?
(State or country) Md.

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) ?

14 Informant Records of
(Address) BALTIMORE CITY HOSPITALS

15 Date received APR 8 - 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-7-29

17 I HEREBY CERTIFY, That I attended deceased from 3-22, 1929, to 4-7, 1929, that I last saw h[illegible] alive on 4-7, 1929 and that death occurred, on the date stated above, at 6 45 A.m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic, with Mitral insufficiency

? (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis & Hypertension

? (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Marvin M. M. Shaw, M. D.

19 ..... (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	April 9 1929
20 UNDERTAKER	ADDRESS
Geo M. Fonticone	811 N Monroe

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44843

CERTIFICATE OF DEATH

101-001

E 44843

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1800 N. Caroline ST. 9-17 WARD)

2—FULL NAME George Hackmann.

(a) RESIDENCE NO. 1800 N. Caroline ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Wilhemina C. Hackman.

DATE OF BIRTH (month, day, and year) Dec 20 1854

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	3	15	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Store Keeper

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

BIRTHPLACE (city or town) (State or country) Germany.

10 NAME OF FATHER George Hackemann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

Informant Wilhemina Hackmann.

(Address) 1800 N. Caroline st.

Filed ... 19 ... JOHNSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 5 '29

17 I HEREBY CERTIFY, That I attended deceased from Mar 30, 1929, to Apr 5, 1929,

that I last saw him alive on Apr 5, 1929

and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Cardiac failure

(duration) ....yrs. ....mos. 1 ....da.

CONTRIBUTORY (Secondary) Senile Pneumonia

(duration) ....yrs. ....mos. 7 ....da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John W Sanderson, M. D.

. 19 (Address) 1714 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: 4/8 1929

20 UNDERTAKER: Geo. L. Ruth

ADDRESS: 1735 Harford ave

Spec.—1-12-23—M&T—500 Bks.

E 44844 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101 - E 44844

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1502 E Madison ST. J-13 (WARD)

2-FULL NAME John Neville

(a) RESIDENCE NO. 1502 E Madison ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Vinie Neville

6 DATE OF BIRTH (month, day, and year) 1884 mos 26

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	45		8.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N.C.

PARENTS

10 NAME OF FATHER John Neville

11 BIRTHPLACE OF FATHER (city or town) (State or country) N C

12 MAIDEN NAME OF MOTHER Matilda Hughes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N C

14 Informant Rachial Wilson

(Address) 1502 E Madison St

15 Filed 4-8-1929 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4 1929

17 I HEREBY CERTIFY, That I attended deceased from 4-1, 1929, to 4-4, 1929, that I last saw him alive on 4-4-29, and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Calvin B LeCompte, M. D.

, 19 (Address) 814 N. Carolina St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary — DATE OF BURIAL April 8 1929

20 UNDERTAKER Robt E Williams ADDRESS 1515 McElderry St

Spec.—1-10-21—M&T—1500 Blks.

E 44845 HEALTH DEPARTMENT—CITY OF BALTIMORE E 44845

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 22 E. Montgomery St. WARD 23

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James. Easton. Norris

(a) RESIDENCE NO. 22 E. Montgomery St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single, Married~~, Widowed, ~~or Divorced~~, (write the word): Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Georgiana Norris

6 DATE OF BIRTH (month, day, and year): Feb. 6th 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73.	2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired 800

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): St. Marys Co Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 6, 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb. 8, 1929, to April 6, 1929, that I last saw him alive on April 5, 1929, and that death occurred, on the date stated above, at 7:50 a.m.

The CAUSE OF DEATH* was as follows: Valvular lesion of heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical.

(Signed) A. Nann, M. D.

, 19 (Address) 12 E. Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

14 Informant (Address): Mrs. Margaret Simmons 22 E. Montgomery st.

15 Filed 1929 CHAMPION JONES, M. D. Registrar

Per

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Co Md. Millstone

DATE OF BURIAL: April 8 1929

20 UNDERTAKER: Fred A. Weaver's Son

ADDRESS: 703 Monroe

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44846

100-001

CERTIFICATE OF DEATH.

E 44846

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hos ST. 19-28 WARD)

2-FULL NAME Amelia Schickner

(a) RESIDENCE NO. 230 S. Calhoun ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 25th 27

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Thomas Schickner

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Amelia Fehr

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Amelia Schickner (Address) 230 S. Calhoun St

15 Filed 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5 1929

17 I HEREBY CERTIFY, That I attended deceased from March 29, 1929 to April 5, 1929, that I last saw her alive on April 5, 1929, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Bronchop-pneumonia - Bilateral

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) Frederick L. Wolf M. D.

4-5-1929 (Address) Sinai Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem. DATE OF BURIAL April 8th 29

20 UNDERTAKER A. Jones ADDRESS 1114 S. Gilmor

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 44847

REGISTERED E 44847

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. John Hopkins Hosp. St. 8-17 Ward)

2-FULL NAME James Valentine

(a) RESIDENCE NO. 1721 Ellsworth St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	C.	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 4, 1929

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
		3	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Ruthsville Valentine

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Ida Bell

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Ruthsville Valentine
(Address) 1721 Ellsworth St.

15 Filed APR 8 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 5/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

General Tuberculosis - miliary
Tubercular Meningitis
Old lesion of upper rt lung.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes at Hopkins

What test confirmed diagnosis?

(Signed) J. H. Yates, M. D.

4/8/29 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Snicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Calvary	Apr. 8 1929

20 UNDERTAKER Mrs. R. A. Elliott ADDRESS 1725 Aisquith

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

4087

2 E 44848

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44848

CERTIFICATE OF DEATH

X 67-dd

1—PLACE OF DEATH JOHNS HOPKINS HOSPITAL REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thomas Lewis Jr.

(a) RESIDENCE NO. 322 Union St. ST. Westchester Pa WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, ~~Married~~, Widowed, or ~~Divorced~~, (write the word): Baby

a If married, widowed, or divorced ~~HUSBAND of~~ (or) ~~WIFE~~ of

6 DATE OF BIRTH (month, day, and year) Mar. 7 1928

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
Year ~~13 Mos~~	1	1	?	

7 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

8 BIRTHPLACE (city or town) (State or country) Pa

10 NAME OF FATHER Thomas W. Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Sarah Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

Informant Parents

(Address) JOHNS HOPKINS HOSPITAL

Filed 4-8-1929 J. HAMPSON JONES, M. D. Registrar

R8-1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7/29

17 I HEREBY CERTIFY, That I attended deceased from April 5, 1929, to April 7, 1929, that I last saw h in alive on April 7, 1929 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Encephalitis, Lead.

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 2 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) J. C. Goodwin, M. D.

4/7, 1929 (Address) Johns Hopkin Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery, Mt Chester Pa — DATE OF BURIAL: Apr. 10 1929

20 UNDERTAKER: Wm Tuckwell & Sons — ADDRESS North & Fa

Spec.—2-29-28—L. F. S.—500 Bks.

E 44849 HEALTH DEPARTMENT—CITY OF BALTIMORE E 44849

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 27-42

CITY OF BALTIMORE: (No. 3712 Overlea Ave ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Matthew Cummings

(a) RESIDENCE NO. 3712 Overlea Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of S. Lillian Cummings

7 DATE OF BIRTH (month, day, and year) Sept. 7, 1884

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	44	7	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance Collector

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Home Friendly Ins Co.

9 BIRTHPLACE (city or town) Long Green Md.
(State or country)

10 NAME OF FATHER John H Cummings

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Margret Callahan

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

Informant Mrs. S. Lillian Cummings

(Address) 3712 Overlea Ave.

Filed R 8 1929 C. HAMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 7, 1929

17 I HEREBY CERTIFY, That I attended deceased from Mar 31 1929 to Apr 7 1929.

that I last saw h alive on Apr 7 1929.

and that death occurred, on the date stated above, at 11.30 A m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Acute Cardiac failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Alfred Hoffman, M. D.

4/8, 1929 (Address) Maplewood, Belair Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem.	Apr. 9 1929
UNDERTAKER	ADDRESS
Wm J Tucker & Sons	North Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

90

E 44850

CERTIFICATE OF DEATH

E 44850

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1935 E. Balto. ST., 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Eleanora L. Richter Johnson

(a) RESIDENCE NO. 1935 E. Balto ST., 2 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W.	Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Mordecai Monroe T. Johnson

6 DATE OF BIRTH (month, day, and year) July 20th 1842

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
86	8	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Co Md.
(State or country)

10 NAME OF FATHER Henry Cronhardt

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Henrietta Schwar

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Miss Tina Cronhardt
(Address) 1935 Edmondson Ave

APR 8 - 1929

C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4th/29

17 I HEREBY CERTIFY, That I attended deceased from Feb 15, 19 29, to April 4, 19 29

that I last saw her alive on April 4, 19 29

and that death occurred, on the date stated above, at 3:05 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular disease

About 1 year
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure
(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual.

(Signed) M. Ephraim, M. D.

, 19 (Address) 1904 E Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	April 8th 19 29
20 UNDERTAKER J. F. Tully & Son Inc.	ADDRESS 404 N. Wolfe St

Cor.—10-10-29—A Co.—100 Bks.

E 44851

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓ E 44851

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 3805 Old York Road St., 9-47 Ward)

2-FULL NAME Margaret L Duffey

(a) RESIDENCE NO. 3805 Old York Road St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of W. J. Duffey

6 DATE OF BIRTH (month, day, and year) Feb 22/1856

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	73	1	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None MD
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md.
(State or country)

PARENTS

10 NAME OF FATHER James Hazelett

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Scotland

12 MAIDEN NAME OF MOTHER Mary Lynch

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Miss Rita Wiedefield
(Address) 914 Greenmount Ave

Filed 4-8 1929 HAMPSON JONES M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 6/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J S A Gore M. D.

4/8/29 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross — DATE OF BURIAL April 9 1929

20 UNDERTAKER Rita Wiedefield — ADDRESS 914 Greenmount Ave

Important. See instructions on back of certificate.

Spec.—1-13-23—MAT—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44852

CERTIFICATE OF DEATH.

1629

E 44852

1-PLACE OF DEATH Baltimore Md

CITY OF BALTIMORE: (No. 609 N Bentalou ST. 16-69 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank P. Derr

(a) RESIDENCE No. 609 Bentalou ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: married

6 DATE OF BIRTH (month, day, and year): Nov 7 52

7 AGE: 76 Years; Nov. 7- Months: 5 Days: 8 If LESS than 1 day, hrs or min.: 0

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Merchant

(b) General nature of industry, business, or establishment in which employed (or employer): 043

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Israel Derr

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Brise

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mary A Derr

(Address) 609 N Bentalou

Filed 3-1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-7 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1929, to 4-7, 1929, that I last saw him alive on 4-7, 1929, and that death occurred, on the date stated above, at 10 40 P. m.

The CAUSE OF DEATH* was as follows:

General Debility, 4 gradual weakness

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Old age

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Medical & Physical Facts

(Signed) Thos H Phillips, M. D.

, 19 (Address) 2300 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: April 10 1929

20 UNDERTAKER: M McKeon

ADDRESS 2228 N Mtd

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44853

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

101

E 44853

CITY OF BALTIMORE: (No. 5230 Oxford ST. 17-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie C. Ross

(a) RESIDENCE NO. 5230 Oxford ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. Ross

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	11 LESS than 1 day, ...hrs. or ....min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Delta, Md

PARENTS

10 NAME OF FATHER Nicholas Gibson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Delta, Md

12 MAIDEN NAME OF MOTHER Phebe Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Delta, Md

14 Informant (Address) Mary Ross 1911 Eutaw Franklin St.

15 Filed APR 8 1929 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5 1929

17

I HEREBY CERTIFY, That I attended deceased from April 1, 1929, to April 5, 1929, that I last saw her alive on Apr. 5, 1929, and that death occurred, on the date stated above, at 11 20 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

Apr. 8, 1929 (Address) 729 Cook. Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
M. Gibson Cemetery, Delta Md	April 8 1929
20 UNDERTAKER	ADDRESS
Wm. Katie R. Williams	N. Schroeder

Spec.—1-10-21—M&T—1500 Bks.

E 44854 HEALTH DEPARTMENT—CITY OF BALTIMORE E 44854

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH Bonnie's Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 27-55 ST. (WARD)

2-FULL NAME Mary Katie Smith Burger

(a) RESIDENCE NO. 3703 Clarks Lane ST., 32 WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced (or) WIFE of Frederick Burger

6 DATE OF BIRTH (month, day, and year) Aug. 29, 1868

7 AGE: Years 60 Months 7 Days 9 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER John David Smith

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Heil

13 BIRTHPLACE OF MOTHER (city or town) Darmstadt (State or country) Germany

14 Informant Mrs. David Smith (Address) 2429 Eutaw Pl. ave.

15 Filed APR 8 - 1929 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7 1929

17 I HEREBY CERTIFY, That I attended deceased from April 6, 1929, to April 7, 1929, that I last saw h[illegible] alive on April 7, 1929, and that death occurred, on the date stated above, at 12.55 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of ovary

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Metastatic Cancer of liver & ascites (duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Oct. 18, 1928

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Elise J. Moodyce, M. D.

, 19 (Address) Bonnie Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Hill Cem. DATE OF BURIAL April 9 1929

20 UNDERTAKER Chas. E. Doench ADDRESS 65 W Madison St

Cor.—10-10-29—A Co.—100 Bks.

E 44855

Julius Doeller

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001

E 44855

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Balt City Hospital St., 7-10 Ward)

2-FULL NAME Julius F. Doeller

(a) RESIDENCE NO. 506 N Paca St St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 1mth yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 5 1872

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	56	8	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Baker
(b) General nature of industry, business, or establishment in which employed (or employer) Journeyman
(c) Name of employer Confectioner

9 BIRTHPLACE (city or town)
(State or country) Germany

PARENTS

10 NAME OF FATHER Robert Doeller

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Paul Miller
(Address) 501 N Paca St

15 Filed 19 H. HAMPSON JONES, M. D., Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5 1928

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Jurors (Inquest, autopsy or inquiry) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 506 N Paca

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

April 6, 1928 (Address) 700 Cathedral

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem

DATE OF BURIAL April 9 1928

20 UNDERTAKER Wm. C. Miller & Son

ADDRESS 2304 Eastern Ave

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 44856

REGISTERED NO. E 44856

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 3608 Fairview St., (Ward) 15-61

2-FULL NAME Franklin T Benson

(a) RESIDENCE NO. 3608 Fairview St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 13 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frances Benson

6 DATE OF BIRTH (month, day, and year) Aug 22 — 1862

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	66	7	13 / 14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Minister
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Benj. F Benson

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Victoria Thomas

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Frances Benson
(Address) 3608 Fairview

Filed ... 1929 HAMPSON JONES, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) ... yrs. Sudden

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) J. H. Gluck, M. D.

April 6th 1929 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	April 8 1929

20 UNDERTAKER John O Mitchell Jr. ADDRESS 1101 Eutaw Pl

Important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44857

CERTIFICATE OF DEATH.

E 44857

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 414 Forrest St. 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vincent Cefalu

(a) RESIDENCE NO. 414 Forest St. Ward Washington DC

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 21. 1927

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	1	5	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. ditto

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Washington D.C.

(State or country)

PARENTS

10 NAME OF FATHER Filippo Cefalu

11 BIRTHPLACE OF FATHER (city or town) Italy

(State or country)

12 MAIDEN NAME OF MOTHER Rosolia Cefalu

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Lawrence mass

14 Informant John Cefalu

(Address) 414 Forest St

Filed 1929 HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-7- 1929

17 I HEREBY CERTIFY, That I attended deceased from 4-3- 1929, to 4-7- 1929, that I last saw him alive on 4-7 1929 and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows: Double Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) S. D Ellard M. D.

48- 1929 (Address) medical arts bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Vincent Cemetery Date of Burial 4/8 1929

20 UNDERTAKER Geo J Ruth ADDRESS 1735 Harford ave

R8 1929

Spec.—12-9-25—A Co.—200 Bks.

Frances Kucera

E 44858

HEALTH DEPARTMENT CITY OF BALTIMORE

E 44858

CERTIFICATE OF DEATH.

101-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 828 N Chapel St., 7-13 Ward)

2-FULL NAME Frances Kucera

(a) RESIDENCE NO. 828 N Chapel St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? 26 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Victor Kucera

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: 63 — Months: — Days: — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) Bernreck Czecho Slovakia

(State or country) Bohemia

PARENTS

10 NAME OF FATHER Jan Morava

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Bohemia

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Bohemia

14 Informant: Victor Kucera

(Address) 828 N Chapel

Filed ... 19 ...

H. HAMPSON JONES, M. D. Registrar

By ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7 1929

17 I HEREBY CERTIFY that I attended deceased from April 5 1929 to April 7 1929, that I last saw h..... alive on ....., 19....., and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH was as follows:

(a) Lobar Pneumonia

(duration) ... yrs. 1 mos. 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Probably

(duration) ... yrs. ... mos. ... ds.

If Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) A. Lafferty M. D.

4-8-29 (Address) 800 N Dallas

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Hill — Date of Burial: April 10 1929

20 UNDERTAKER: Ernest Crockett — ADDRESS: 1400 Eutaw

Key Important. See Instructions on Back of Certificate.

PR8-1926

Spec.—1-10-21—M&T—1500 Bks.

E 44859

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44859

CERTIFICATE OF DEATH. X 90 E [redacted]

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Bon Secours Hospital (ST.) 2100 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rev. John M. Nary S. S.

(a) RESIDENCE NO. St. Charles College (ST.) Catonsville Md. (WARD)

(Usual place of abode)

Length of residence in city or town where death occurred [redacted] yrs. 6 mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 17-1850

7 AGE — Years: 79 — Months: — — Days: 20 19 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Catholic Priest

(b) General nature of industry, business, or establishment in which employed (or employer): 018

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Rev Eugene Harrigan (Address) St Charles College

15 Filed 8-1929 C. HAMPTON JONES, M. D. Registrar Reg'd 1609

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 2 1928 to April 6 1929

that I last saw him alive on April 6 1929

and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Hypostatic pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerotic cardio-vascular disease & Cerebral hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 7 mos.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Theo E Stacy Jr. M. D.

, 19 (Address) Bon Secours Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: 4 9 1929

UNDERTAKER: Chas. F. Grauel Son

ADDRESS: 1810 W. Royal Ave

Spec.—1-12-23—M&T—500 Bks.

44860

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101 E 44860

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1508 Millinear ST. 9-13 WARD)

2-FULL NAME James Mortimore

(a) RESIDENCE NO. 1508 Millenan St. ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Irene Mortimore

6 DATE OF BIRTH (month, day, and year) Dec. 1889

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
39 yrs	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Sylvester Mortimore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Ellen Pinder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Hermantha Stanley (Sister)
(Address) 1508 Millenant.

15 Filed 4-8-1929 C. THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 1929

17 I HEREBY CERTIFY, That I attended deceased from April 4, 1929, to April 6, 1929, that I last saw him alive on April 6, 1929, and that death occurred, on the date stated above, at 9 10 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. mos ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. D. Compte, M. D.

, 19 (Address) 5129 Carlin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cambridge Md

DATE OF BURIAL 4-8 1929

20 UNDERTAKER Jas. Jno Skinner

ADDRESS 1625 E. Madison

Cor.—10-10-29—A Co.—100 Bks.

E 44861

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44861

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of Baltimore: (No.) S.W. cor Read & Park Sts. (Ward) 11-24

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Cecelia Rainey

(a) RESIDENCE S.W. cor Read & Park Sts. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of No.

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	55			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework at home.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Ireland
(State or country)

PARENTS

10 NAME OF FATHER Robt Rainey

11 BIRTHPLACE OF FATHER (city or town) Ireland.
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant (Address) Mrs Basil Wagner Garrison Md

15 Filed Apr 8 1929 C. HAMPSON JONES, M. D. Registrar

RB - 1923 ... 1000

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:

Angina Pectoris.

(duration) ... yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted If not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) F. Edw Leitz, M. D.

Apr 8 29 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 4/9 1929

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44862 | CERTIFICATE OF DEATH 129 | E 44862

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2253 Sidney ST. 5-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lillian Mary Wahl

(a) RESIDENCE NO. 2253 Sidney ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Ernest E.

7 DATE OF BIRTH (month, day, and year) Sept 14 1878

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	7	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

10 NAME OF FATHER Charles Gontzom

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

Informant Ernest E Wahl

(Address) 2253 Sidney St

APR 8 - 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7-29

17 I HEREBY CERTIFY, That I attended deceased from March 31, 1929, to April 7, 1929, that I last saw her alive on April 4, 1929 and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(duration) 10 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Edema

(Signed) R D Glass, M. D.

April 7 1929 (Address) Lakeland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet — DATE OF BURIAL 4/10 1929

20 UNDERTAKER William Cook — ADDRESS 1217 St Paul

Spec.—2-29-28—L. F. S.—500 Bks.

E 44863

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44863

CERTIFICATE OF DEATH

31

1—PLACE OF DEATH

REGISTERED NO. 913

CITY OF BALTIMORE: (No. Sydenham Hospital ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rosie Gibson

(a) RESIDENCE NO. 1025 McCulloh St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. 7 mos. 24 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 14, 1909

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	19	7	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Henry Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Maria Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Henry Williams

(Address) 1025 McCulloh

15 APR 8 - 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 4, 1929, to April 7, 1929, that I last saw h-- alive on April 6, 1929 and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Tuberculous Meningitis

(duration) yrs. mos. 14d.

18 Where was disease contracted if not at place of death? 1025 McCulloh St.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis Clinical findings, spinal puncture

(Signed) Addison Craft Tull, M. D.

4-7-1929 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	4/8/1929
UNDERTAKER	ADDRESS
Geo. A. Holland	1631 Druid Hill Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

49 L 44864

E 44864

CERTIFICATE OF DEATH

1—PLACE OF DEATH St Josephs Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No.) Caroline & Orleans ST., (WARD) 5 6

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank Foley

(a) RESIDENCE NO. 830 E Read ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ellen Kelly Foley

7 DATE OF BIRTH (month, day, and year): Sept 17, 1864

8 AGE: Years 64 | Months 5 6 | Days 17 | If LESS than 1 day, hrs. or min.

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Watchman

(b) General nature of industry, business, or establishment in which employed (or employer): 16 yrs

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Baltimore Md.

10 NAME OF FATHER: John W. Foley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Lennon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

Informant: Mary A. Foley

(Address) 1811 Covington St

Filed 8-1929, 19

C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-6-1929

17 I HEREBY CERTIFY, That I attended deceased from 10-21-28, 19, to 4-6-29, 19, that I last saw h alive on 4-6-29, 19, and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Cancer urinary Bladder

2 (duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Paralysis

(duration) yrs. mos. 30 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of none

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) J B Hundley M. D.

, 19 29 (Address) Jewish Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: Mar. 9 19 29

20 UNDERTAKER: Margaret E. Flynn — ADDRESS: 1432 Light St.

Spec.—1-12-23—M&T—500 Bks.

E 44865 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 40 **E 44865**

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Home for Incurables

CITY OF BALTIMORE: (No. 40th ST. or Cedar Ave ST.) 13-52 (WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriet A. Burrier

(a) RESIDENCE No. 3535 Roland Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	White	Widowed

5a If married, widowed, or divorced (or) WIFE of William A Burrier

6 DATE OF BIRTH (month, day, and year) May 17, 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min
	84	10	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Invalid

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Emmetsburg Frederick County

PARENTS

10 NAME OF FATHER Lewis Webb

11 BIRTHPLACE OF FATHER (city or town) (State or country) Frederick County

12 MAIDEN NAME OF MOTHER Nancy Nugent

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Frederick County

14 Informant James A Barrier

(Address) 4133 Gallow Road

15 Filed 8-3-1929 C. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 6 1929

17 I HEREBY CERTIFY, That I attended deceased from May 24, 1927 to Apr 5, 1929 that I last saw her alive on April 5 1929 and that death occurred, on the date stated above, at 10 20 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary edema

(duration) yrs. mos 6 ds.

CONTRIBUTORY (secondary) Chr. Myocarditis & decompensation (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Physical Exam.

What test confirmed diagnosis?

(Signed) W M B Mayo M. D.

4/6, 1929 (Address) Medical Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	Apr 9 1929
UNDERTAKER	ADDRESS
A M Marshall	3539 Fallsway

Spec.—1-12-23—M&T—500 Blks.

E 44866

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 44866

1-PLACE OF DEATH Provident Hospital

CITY OF BALTIMORE: (No. 1514 Division St. 17-24 WARD)

REGISTERED NO. 100-01

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Baker

(a) RESIDENCE No. 736 Bradley ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced. (write the word): infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: infant

6 DATE OF BIRTH (month, day, and year): 4/5/29

7 AGE — Years: — Months: 3 Days: — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: infant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balt. Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address):

15 C. HAMPSON JONES, M. D. Registrar

1929 No. 3361 ACH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 5 1929

17 I HEREBY CERTIFY, That I attended deceased from Apr 4, 1929, to Apr 5, 1929, that I last saw h[illegible] alive on Apr 5, 1929, and that death occurred, on the date stated above, at 8[10] A m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Transition.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Undetermined

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) [signature] M. D.

Apr 5 19 29 (Address) Prov. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND.

DATE OF BURIAL 19

20 UNDERTAKER: Commissioner of Health.

ADDRESS APR 8 - 192

Spec.—2-29-28—L. F. S.—500 Bks.

E 44867

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

161-001

E 44867

1—PLACE OF DEATH

REGISTERED NO. 24-33

CITY OF BALTIMORE: (No. University Hoop ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby boy Vetters

(a) RESIDENCE NO. 316 E. Hamburg ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 4/3/29

7 AGE: 3 days — Years | Months | Days | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Hattie

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant

(Address)

15 Filed C. HAMPSON JONES, M. D. City Registrar

APR 8 - 1929 By 340

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/5/29

17 I HEREBY CERTIFY, That I attended deceased from 4/4/, 1929, to 4/5/, 1929, that I last saw h.l. alive on 4/5/, 1929 and that death occurred, on the date stated above, at 3.30 a. m.

The CAUSE OF DEATH* was as follows:

prematurity

atelectasis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Henry Ginsberg, M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

APR 8 - 1929

Spec.—2-29-28—L. F. S.—500 Bks.

E 44868 HEALTH DEPARTMENT—CITY OF BALTIMORE E 44868

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 161-00

CITY OF BALTIMORE: (No. 1236 W. Fayette (ST.) 16-23 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Moore

(a) RESIDENCE NO. 1236 Fayette ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) City
(State or country)

10 NAME OF FATHER not known

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Nathan Moore

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant

(Address)

15 Filed APR 3 - 1929, 19 For C. HAMPSON JONES, M. D.
3162 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/7/29

17 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....,

that I last saw h..... alive on ....., 19.....

and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. M. D.

4/7, 19 29 (Address) H. C.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

APR 3 - 1929

Spec—12-23-21—E.B.R.S.—400 Bks.

E 44869 HEALTH DEPARTMENT—CITY OF BALTIMORE E 44869

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

City of BALTIMORE: (No. 1241 James St., 21-29 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nellie Estelle Kincaid

(a) Residence No. 1241 James St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX	4-COLOR OR RACE	5-Single, Married, Widowed, or Divorced, (Write the word.)
Female	White	Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) Feb 24 28

7-AGE, 1 yrs. 2 mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country), Md.

PARENTS.

10-NAME OF FATHER, Lester Kincaid

11-BIRTHPLACE OF FATHER (city or town) Virginia (State or Country),

12-MAIDEN NAME OF MOTHER, Ruby Marshall

13-BIRTHPLACE OF MOTHER (city or town) Virginia (State or Country),

14- (Informant) Lester Kincaid

(Address) 1241 Jas St

15- Filed 1929 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 4/6/29

17- I HEREBY CERTIFY, That I attended deceased from April 1, 1929, to April 6, 1929, that I last saw h[illegible] alive on April 6, 1929, and that death occurred, on the date stated above, at 11:30 A.M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(Duration) yrs. mos. 3 ds.

18-Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edgar Turner M. D.

, 19 (Address) 1500 Hollins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. PUBLIC CEMETERY. DATE OF BURIAL. 19

20-UNDERTAKER. ADDRESS

Commissioner Health.

APR 8-1929

APR 8-1929

Spec.—1-12-23—M&T—500 Blks.

E 44870 HEALTH DEPARTMENT—CITY OF BALTIMORE E 44870

CERTIFICATE OF DEATH.

1-PLACE OF DEATH West Baltimore General REGISTERED NO. X 129

CITY OF BALTIMORE: (No.) ST. 16-66 (WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Susie Curley.

(a) RESIDENCE NO. Laurel Md. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Peter Curley

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Hospital Record (Address)

15 Filed 4-8-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/8, 1929

17 I HEREBY CERTIFY, That I attended deceased from 4/7, 1929 to 4/8, 1929 that I last saw h. alive on 4/8/1929, and that death occurred, on the date stated above, at 12-Noon

The CAUSE OF DEATH* was as follows:

Cardio-Renal Vascular disease - Hypertensive

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Berry Sanders, M. D.

4/8, 1929 (Address) West Balto. General

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Md DATE OF BURIAL 4, 10, 1929

20 UNDERTAKER Lloyd Frazier ADDRESS Laurel Md

Spec.—2-29-28—L. F. S.—500 Bks.

E 44871

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 44871

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3202 Mc, Elderry ST. No-15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph Fermes

(a) RESIDENCE NO. 3202, Mc, Elderry ST., 6 WARD
(Usual place of abode)

Length of residence in city or town where death occurred (yrs. 55 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Fermes

DATE OF BIRTH (month, day, and year) Feb, 8, 1757

AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
72	01	29	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Musician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer None

BIRTHPLACE (city or town) (State or country) Italy

10 NAME OF FATHER Donato Fermes

11 BIRTHPLACE OF FATHER (city or town) Italy (State or country)

12 MAIDEN NAME OF MOTHER Catherine Distafano

13 BIRTHPLACE OF MOTHER (city or town) Italy (State or country)

Informant Margaret Murphy

(Address) 3200 McElderry St

Filed APR 8 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apl 7 '29

17 I HEREBY CERTIFY, That I attended deceased from March 14, 1929, to Apl 6, 1929, that I last saw him alive on Apl 6, 1929, and that death occurred, on the date stated above, at 2.50 m.

The CAUSE OF DEATH* was as follows:

a Myocarditis (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Emphysema (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? No.

(Signed) Hugh Forsythe, M. D.

Apl 8, 1929 (Address) 422 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New cathedral

DATE OF BURIAL 4/10/29 19

20 UNDERTAKER Frank V Pipitone

Frank V. Pipitone

ADDRESS 2818 E, Balto

Spec.—2-29-28—L. F. S.—500 Bks.

Todd V Eastern Ave

E 44872

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44872

CERTIFICATE OF DEATH

129

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 6700 Hudson ST. No 37 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph A Horning

(a) RESIDENCE NO. 6700 Hudson ST.,

(Usual place of abode) WARD

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Julia A Horning

DATE OF BIRTH (month, day, and year) Jan 18 1864

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	2	22	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Eastern Rolling Mill

BIRTHPLACE (city or town) Baltimore (State or country) Md

10 NAME OF FATHER Jacob Horning

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Julia Kurz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

Informant Joseph A Horning

(Address) 6700 Hudson St

Filed 8-1929 19 HAMPSON JONES M. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7th 1929

17

I HEREBY CERTIFY, That I attended deceased from March 15th 1929 to April 7th 1929

that I last saw him alive on March 11th 1929

and that death occurred, on the date stated above, at 2.20 p.m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis.

Duration

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dilated Heart

Edema (duration) yrs. 2 mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Agnes Lord M. D.

19 (Address) 4700 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart

DATE OF BURIAL 4 10 1929

20 UNDERTAKER A. McCoy

ADDRESS 1217 Mad

Spec.—2-29-28—L. F. S.—500 Bks.

9-E 44873 (9-30 336)

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 44873

CERTIFICATE OF DEATH × 90

1—PLACE OF DEATH JOHNS HOPKINS HOSPITAL REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Laughlin McKellar

(a) RESIDENCE NO. Elizabeth Sa — ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Elizabeth

6 DATE OF BIRTH (month, day, and year) 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5-6			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Supt. of

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Tex-

10 NAME OF FATHER Peter McKellar

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Carrie Tanner

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

Informant Records

(Address) JOHNS HOPKINS HOSPITAL

Filed 8-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8-29

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1928 to April 8, 1929, that I last saw him alive on April 8, 1929 and that death occurred, on the date stated above, at 8 30 Am.

The CAUSE OF DEATH* was as follows:

Arterial Sclerosis,
Chronic Myocarditis
Hypertension

(duration) yrs. ? mos. , ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. ? ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? general & Laboratory

(Signed) R. Hooper Small, M. D.

April 7 1929 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Elizabeth La	April 8 1929
20 UNDERTAKER	ADDRESS
Edw. O. Mitchell Sons	1900 Eastland Ave

Spec.—2-29-28—L. F. S.—500 Bks.

22385-S

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 44874

CERTIFICATE OF DEATH

E 44874

1—PLACE OF DEATH Johns Hopkins Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 7-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Horace Hunt.

(a) RESIDENCE NO. 812 N. Washington St WARD
(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
male	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1903

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
26			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Orderly

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

10 NAME OF FATHER Francis Hunt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Eng Land

12 MAIDEN NAME OF MOTHER Carolyn Bottomley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

Informant Records

(Address) Johns Hopkins Hospital

F[illegible] -1929 C. H. HAMPSON JONES, M. D.
[illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5-29

17

I HEREBY CERTIFY, That I attended deceased from March 29, 1929, to April 5-, 1929, that I last saw him alive on April 6-, 1929 and that death occurred, on the date stated above, at 2-15 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) — yrs. — mos. 8 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) A. Hadsalaw, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL 4/8/29

20 UNDERTAKER Joseph Ahrens

ADDRESS 221 Bway

Cor.—1-12-23—M&T—100 Bks.

E 44875 HEALTH DEPARTMENT—CITY OF BALTIMORE **E 44875**

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Union Memorial Hospital ST. 3500 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Joseph Brannan Jr

(a) RESIDENCE No. 1910 Union ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W.	married

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of Mary G Brannan

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Car Repairer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Penn R R.

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER James J Brannan Jr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Mulligan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary G Brannan
(Address) 1910 Union ave

15 Filed 4-8 1929 192 C. HAMPSON JONES, M. Registrar
By ARH

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/7 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Alcoholism

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Jno Morrison, M. D.
4/8 1929 (Address) 3632 Roland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer DATE OF BURIAL 4 9 1929

UNDERTAKER Martin Fahey & Son ADDRESS 1837-11 North ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44876

CERTIFICATE OF DEATH

31 E 44876

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 522 Laurens ST. 14-20 (WARD)

2—FULL NAME Edith Williams

(a) RESIDENCE NO. 522 Laurens ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 18, 1928

7 AGE — Years: 1 | Months: 1 | Days: 19 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: child

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto, md

10 NAME OF FATHER: Richard williams

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Dora. G wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): md

14 Informant: Richard williams

(Address) 522 Lauren's St

15 Filed APR 9 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7, '29

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1929, to April 7, 1929, that I last saw h.. alive on April 6, 1929 and that death occurred, on the date stated above, at 7 9 m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonalis

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) R. M. Leard, M. D.

4/8, 1929 (Address) 2005 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn cemetery — DATE OF BURIAL: April 9 1929

20 UNDERTAKER: Thomas. E Kelson — ADDRESS 1303 Freestman St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44877

CERTIFICATE OF DEATH.

31 E 44877

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2215 Etting St. 14-54 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Smallwood

(a) RESIDENCE No. 2215 Etting ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Hester Smallwood

6 DATE OF BIRTH (month, day, and year) Nov 14 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	59	4	22 23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Easton Md

PARENTS

10 NAME OF FATHER Joseph Smallwood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Smallwood

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Hester Smallwood (Address) 2215 Etting St

Filed ..., 19... Per ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 6 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb 25, 1929, to Apr 6, 1929, that I last saw him alive on Apr 4, 1929, and that death occurred, on the date stated above, at 4:10 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum

(Signed) William Frey, M. D.

4/6, 1929 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

UNDERTAKER Thomas E. Kelson

DATE OF BURIAL 4/9 1929

ADDRESS 1303 Pressman St

APR 8 - 1929 C. HAMPSON JONES, M. D. Registrar

Spec.—6-9-19—H. P. Co.—1000 Bks.

(Himler)

E 44878 HEALTH DEPARTMENT—CITY OF BALTIMORE E 44878

CERTIFICATE OF DEATH. X 129

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: No. 3208 Chesley Ave ST. 7-43 WARD)

2-FULL NAME Mrs Sarah Himler

(a) RESIDENCE. No. 3208 Chesley Ave ST., WARD Westminster Md
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 6 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71		3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Andrew J Easton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Margt Angy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Earl Ulrich
(Address) 3207 Chesley Ave Balto

15 Filed . 19

8-1929 C. HAMPSON JONES, M. D. Registrar.
Dep —

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/8 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan, 1929, to 4/8, 1929, that I last saw h alive on 4/8, 1929 and that death occurred, on the date stated above, at 5-30 m.

The CAUSE OF DEATH* was as follows:

Asthma Sclerosis
Chr. Interstitial Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Myla W Gilley, M. D.

, 19 (Address) 5703 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Westminster Md	4-12 19

20 UNDERTAKER H Bankard & Son ADDRESS Westminster Md

Spec.—2-29-28—L. F. S.—500 Bks.

E 23983
E 44879

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

32 E 44879

1—PLACE OF DEATH JOHNS HOPKINS HOSPITAL REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 23-37 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Pauline Blizzard

(a) RESIDENCE NO. 1749 Clarkson ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female.

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of —

7 DATE OF BIRTH (month, day, and year) April. 6/28

8 AGE: Years 1 | Months 0 | Days 1 | If LESS than 1 day, hrs. or min.
12 | 3

9 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grave. [illegible]

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

10 BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER David

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Lillian Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

Informant Records

(Address) JOHNS HOPKINS HOSPITAL

1929 [illegible] [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7-1929

17 I HEREBY CERTIFY, That I attended deceased from April 2, 1929, to April 7, 1929, that I last saw her alive on April 7, 1929, and that death occurred, on the date stated above, at 1.25 A m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) J. L. Goodwin M. D.

4/7, 1929 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem — DATE OF BURIAL: 4/9 1929

20 UNDERTAKER: L. Few McCully — ADDRESS: 130 E. Fort

Spec.—2-29-28—L. F. S.—500 Bks.

E 44880

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

111-001

REGISTERED NO. E 44880

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hospital ST. 8-16 WARD)

2—FULL NAME Henry Finck

(a) RESIDENCE NO. 1745 N. Clinton ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: the late Mary A Finck (nee Fitzpatrick)

6 DATE OF BIRTH (month, day, and year): Oct 26 1871

7 AGE: Years 57 | Months 5 | Days 13 | If LESS than 1 day, hrs. or min.: 14

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: General Labor

(b) General nature of industry, business, or establishment in which employed (or employer): for City

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

10 NAME OF FATHER: John Henry Finck

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Helen B Starck

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant: Daughter Mrs Marie Hawking

(Address) 1520 N. Broadway St.

15 Filed R9 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/8/29

17 I HEREBY CERTIFY, That I attended deceased from 3/16/29, 19..., to 4/8/29, 19..., that I last saw h[illegible] alive on 4/8/29, 19... and that death occurred, on the date stated above, at 9:05 A. m.

The CAUSE OF DEATH* was as follows: perforated gastric ulcer

(duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary): coronary embolism

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 3/16/29

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Course

(Signed) N B Hendrix, M. D.

At Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Most Holy Redeemer Cemetery | DATE OF BURIAL: April 11, 1929

20 UNDERTAKER: Elmer W. Conklin | ADDRESS: 924 E Eager St

Spec.—2-29-28—L. F. S.—500 Bks.

E 44881

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44881

CERTIFICATE OF DEATH

37-001

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST. 4-27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George F. Johnson

(a) RESIDENCE NO. 1519 W. Saratoga st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ella Johnson

6 DATE OF BIRTH (month, day, and year): 1887

7 AGE — Years: 42 | Months: | Days: | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Maryland

10 NAME OF FATHER: Wm. Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Sarah Hamilton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Hospital Records

(Address)

15 Filed 4-9-1929 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 6, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 2, 1929, to April 6, 1929, that I last saw h. im alive on April 6, 1929, and that death occurred, on the date stated above, at 8.30 a. m.

The CAUSE OF DEATH* was as follows:

Miliary tuberculosis

(duration) Four weeks

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Henry Smith, M. D.

4-6-1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: W S National

DATE OF BURIAL: April 10 1929

20 UNDERTAKER: Joseph A Sivley

ADDRESS: 409 N Mount St

Spec.—2-29-28—L. F. S.—500 Bks.

Boone

E 44882

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

118-001

E 44882

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hosp ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Brent

(a) RESIDENCE NO. 1919 Lenard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Widower

a If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year): 1905

AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	24			

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Fisher

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

BIRTHPLACE (city or town) (State or country): Va

10 NAME OF FATHER: James Elliott

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Francis Hines

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

Informant: Vale and Co

(Address) 922 Wilkens Ave Norfolk Va

Filed 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/2/29

17 I HEREBY CERTIFY, That I attended deceased from 3/25, 19 29, to 4/7, 19 29, that I last saw h alive on 4/7, 19 29, and that death occurred, on the date stated above, at 8:45 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) 1 wk yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? No Date of 4/1/29

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. Dan Speck, M. D.

, 19 (Address) Bath Court

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Norfolk Va

DATE OF BURIAL: 4/9 19 29

20 UNDERTAKER: Samuel T Kemsley

ADDRESS 578 W Bute

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44883

CERTIFICATE OF DEATH

X 74-001

E 44883
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 901 Camel ct St.) (Ward) 12th

2-FULL NAME Jas Byrd-Alias-Albert Nance

(a) RESIDENCE NO. 901 Camel ct St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State) New York.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) 1878

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
51	50			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer 040
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Florida.
(State or country)

PARENTS

10 NAME OF FATHER Mack Nance

11 BIRTHPLACE OF FATHER (city or town) Florida.
(State or country)

12 MAIDEN NAME OF MOTHER Amanda Nance

13 BIRTHPLACE OF MOTHER (city or town) Florida.
(State or country)

14 Informant Irene Byrd
(Address) 901 Camel ct

15 Filed 9-1929 C. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Apr 7th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(duration) yrs. Sudden

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) Apr 8th 1929 Reuben Gelick, M. D.
(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Lebanon Cem

DATE OF BURIAL 4/9 1929

20 UNDERTAKER Paul L Dewley

ADDRESS 578 N Bond

Spec.—2-29-28—L. F. S.—500 Bks.

27 3685
E 44884

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001

E 44884

1—PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 5-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Dangerfield

(a) RESIDENCE NO. 1416 Mc Elderry ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M.	B	M

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Blanche

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

10 NAME OF FATHER Geo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Jane Dangerfield

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

Informant Records

(Address) JOHNS HOPKINS HOSPITAL

Filed APR 9 1929 H. HANSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 5 1929

17

I HEREBY CERTIFY, That I attended deceased from March 23, 1929, to April 5, 1929, that I last saw him alive on April 5, 1929 and that death occurred, on the date stated above, at 12 00 P.m.

The CAUSE OF DEATH* was as follows:

Intussusception. Hypertension. Myocardial failure. Bronchopneumonia

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Exam. of tissues.

(Signed) S. A. Gladstone, M. D.

4/6, 1929 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Calvary Cemetery	April 9 1929
20 UNDERTAKER	ADDRESS
Robert E Williams	1515 Mc Elderry St

Spec.–7-17-26—A Co.—200 Bks.

E 44885

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

117 E 44885

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mt Ger. Hosp 30-69 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Letschin

(a) RESIDENCE NO. 1731 Ramsay St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ✓

6 DATE OF BIRTH (month, day, and year): 2/17/28

7 AGE: Years 11 Months 1 Days 19 IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Spool girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Adolph Letschin

11 BIRTHPLACE OF FATHER (City or town): Baltimore

(State or country)

12 MAIDEN NAME OF MOTHER Beulah Smith

13 BIRTHPLACE OF MOTHER (City or town): Baltimore

(State or country)

14 Informant (Address) Hospital Records

15 Filed APR 9 - 1929 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/5/29 19

17 I HEREBY CERTIFY, That I attended deceased from 3/4/29 19 to 4/5/29 19, that I last saw h[illegible] alive on 4/5/29 19, and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis Ruptured

Gen. Peritonitis

Septic Pulmonary (duration) yrs. 1 mos. 39 ds.

CONTRIBUTORY (Secondary)

Abscess (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 3/4/29

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

4/9, 19 Address [illegible]

*State the Disease Causing Death, or in Deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

16 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery Date of Burial Apr. 9 1929

20 UNDERTAKER: George L. Schmidt ADDRESS 2101 Pulaski

Very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 44886

CERTIFICATE OF DEATH

E 44886

1—PLACE OF DEATH

REGISTERED NO. 15-63

CITY OF BALTIMORE: (No. 4011 Boarman ave ST., 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Morris Perlorsky

(a) RESIDENCE NO. 4011 Boarman ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah Perlorsky

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: 60 — Months: — — Days: — — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Tailor

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Russia

10 NAME OF FATHER: Ephraim Perlorsky

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

Informant: Jack Lewis

(Address): 1439 E. Baltimore St.

[illegible] M. D.

4-9-1929

[illegible]

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/8/29

17 I HEREBY CERTIFY, That I attended deceased from March-22-, 1929, to april-8-, 1929, that I last saw h.im alive on april-8- 1929 and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial nephritis

(duration) 2-3 yrs. mos. ds.

CONTRIBUTORY (Secondary): Lobar Pneumonia

(duration) yrs. mos. 0 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) Herman Seidel, M. D.

April 8 1929 (Address) 2404 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale — DATE OF BURIAL: 4/9 1929

20 UNDERTAKER: Jack Lewis 1439 E. Baltimore St — ADDRESS

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44887

CERTIFICATE OF DEATH.

E 44887

1-PLACE OF DEATH West Baltimore General REGISTERED NO.

CITY OF BALTIMORE: (No.) ST. 23 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Lena Simon

(a) RESIDENCE No. 244 S. Eden ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Simon

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 72 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Jack Lewis

(Address) 1439 E. Balto St

15 Filed 4/9 '29 HAMPSON JONES, M. D. Registrar

4-9-1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/8, 1929

17 I HEREBY CERTIFY, That I attended deceased from 3/19, 1929, to 4/8, 1929

that I last saw her alive on 4/8, 1929

and that death occurred, on the date stated above, at 7:25 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Sclerosis & Hemiplegia

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary): Bronchio Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Ben. Samuels, M. D.

4/8, 1929 (Address) West Balto. General.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale — DATE OF BURIAL: 4/9 1929

20 UNDERTAKER: Jack Lewis 1439 E Balto — ADDRESS

Spec.—1-12-23—M&T—500 Bks.

E 44888

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44888

100-001

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Provident Hospt

CITY OF BALTIMORE: (No. Balt. Md ST. 18-16 WARD)

2-FULL NAME Edna Jones

(a) RESIDENCE NO. 871 N Fairmount ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 20, 1928

7 AGE Years ..... Months 10 Days 16 If LESS than 1 day, hrs. ..... or min .....

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balt. Md

(State or country)

PARENTS

10 NAME OF FATHER Walter Jackson

11 BIRTHPLACE OF FATHER (city or town) Balt Md

(State or country)

12 MAIDEN NAME OF MOTHER Mary E Jones

13 BIRTHPLACE OF MOTHER (city or town) Balt. Md

(State or country)

14 Informant Mary Jones

(Address) 871 N Fairmount Ave

15 (Signed) THOMPSON JONES, M. D.

Registrar

APR 9 - 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-6- 1929

17

I HEREBY CERTIFY, That I attended deceased from 4-6- , 1929, to 4-6- , 1929, that I last saw h[illegible] alive on 4-6- , 1929, and that death occurred, on the date stated above, at 7.45 P m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) ..... yrs. ..... mos 6 ds.

CONTRIBUTORY —

(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Undetermined

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) R-L Jackson, M. D.

, 19 (Address) Provident Hospt.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemtery	April 9, 1929
20 UNDERTAKER Mrs. Katie R. Williams	ADDRESS 322 Schroeder St.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44889 E 44889

CERTIFICATE OF DEATH

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 17-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Isaac Johnson

(a) RESIDENCE NO. 60 Holbrook ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1874

7 AGE — Years: 54 — Months: — Days: — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Ind

10 NAME OF FATHER: Wm Matthews

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ind

12 MAIDEN NAME OF MOTHER: Elizabeth Sanders

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ind

14 Informant (Address): BALTIMORE CITY HOSPITALS

15 PR9 - 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/5/29

17 I HEREBY CERTIFY, That I attended deceased from 4/1, 1929, to 7/5, 1929, that I last saw h[illegible] alive on 4/5, 1929, and that death occurred, on the date stated above, at 1h P m.

The CAUSE OF DEATH* was as follows: Carcinoma of Stomach

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 4/3/29

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

, 19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery — DATE OF BURIAL: April 10, 1929

20 UNDERTAKER: Mrs Katie R. Williams — ADDRESS 322 N. Schroeder St.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44890

CERTIFICATE OF DEATH

129 E 44890

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE (No.) 2008 Ething St. (WARD) 14-20

2—FULL NAME Sarah Ellen Beverley

(a) RESIDENCE NO. 2008 Ething ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: James N Beverley

6 DATE OF BIRTH (month, day, and year): Jan 3-1860

7 AGE: Years 69 | Months 3 | Days 3 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Hampton Va

10 NAME OF FATHER: Paul Madison

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Margaret Bates

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

Informant: James N Beverley

(Address) 2008 Ething St

Filed — 1924. H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apl 5 — 24

17

I HEREBY CERTIFY, That I attended deceased from Jan 2, 1924, to Apl 5, 1924, that I last saw h[illegible] alive on Apl 5, 1924, and that death occurred, on the date stated above, at 10 30 A.M.

The CAUSE OF DEATH* was as follows:

Chr. Nephritis

+ Cerebral Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jno F Chetta, M. D.

19 24 (Address) 439 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	4/8 24

20 UNDERTAKER: Samuel J Memsley & Bro ADDRESS 518

Spec.—2-29-28—L. F. S.—500 Bks.

E 44891

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44891

CERTIFICATE OF DEATH

1—PLACE OF DEATH Union Memorial Hosp REGISTERED NO. 12-44

CITY OF BALTIMORE (No. 33 and Calvert ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Josephine E. Brown

(a) RESIDENCE NO. Dresden Apartments ST. Washington D.C. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

SEX F | COLOR OR RACE W | 5 Single, Married, Widowed, or Divorced, (write the word) Widow

a If married, widowed, or divorced HUSBAND of (or) WIFE of H. B. Brown

DATE OF BIRTH (month, day, and year) Nov. 14, 1855

AGE 72 Years 73 | Months 4 ~~3~~ | Days 24 8 | If LESS than 1 day, ...hrs. or ....min.

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ~~None.~~ None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Trenton N. J.

10 NAME OF FATHER Tilson E. English

11 BIRTHPLACE OF FATHER (city or town) (State or country) Trenton N J

12 MAIDEN NAME OF MOTHER Mary Bunting

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New Jersey

Informant Hospital Record

(Address) 33 and Calvert St

R 9-1929 H. HAMPSON JONES, M.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/8/29

17 I HEREBY CERTIFY, That I attended deceased from 3/26/29, 19..., to 4-8-29, 19...,

that I last saw her alive on 4-8-29, 19...

and that death occurred, on the date stated above, at 9.15 P m.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 3/30/29

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George D. Eaton, M. D.

4/9, 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Arlington Nat'l Cem. Va	Apr 11 19 29
20 UNDERTAKER	ADDRESS
Harry Martin & Son	1726 Eutaw Pl

Spec.—1-12-23—M&T—500 Bks.

E 44892

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

35 E 44892

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No. Monument ST 1354 WARD)

2-FULL NAME Mr. Abraham Benesch

(a) RESIDENCE NO. Nel Mr Apts ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosa Benesch

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day.... hrs. or.... min.
	70	4	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Israel Benesch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Mrs Rosa Benesch

(Address) [illegible]

Filed 1929 S. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/8/ 1929

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1928, to April 8, 1929.

that I last saw h[illegible] alive on April 8, 1929.

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Septicemia

(duration) ... yrs. 6 mos ... ds.

CONTRIBUTORY (Secondary) Hypertrophy of Prostate

Heard (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 7/6/28

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Arthur Linde M.D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship

DATE OF BURIAL 4/10/1929

20 UNDERTAKER Heard Goodman

ADDRESS [illegible]

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 44893 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 44893

1-PLACE OF DEATH Baltimore Eye Hosp. REGISTERED NO.

CITY OF BALTIMORE: (No. 1214 Eutaw Place St. 6-11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Norman J. Glass

(a) RESIDENCE. No. 128 N. Hare St., Ward. Baltimore
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. 11 mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 20, 1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23	11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Ward Bakery Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER James Glass

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Effie Enge

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md

14 Informant James H. Glass (Address) 128 N. Hare St.

15 APR 9 - 1929 H. SENG, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-6 1929

17 I HEREBY CERTIFY, That I attended deceased from 4-3, 1929, to 4-6, 1929, that I last saw h[illegible] alive on 4-6, 1929, and that death occurred, on the date stated above, at 10:30 P. m.

The CAUSE OF DEATH* was as follows:

Otitis media for 21 yrs
Mastoiditis 7 days ago.

CONTRIBUTORY (Secondary) Lateral Sinus Thrombosis (duration) yrs. mos. ds.

Infection (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes. Date of 4-5-29

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Ed. H. Jobes M.D. M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	4/10 1929

20 UNDERTAKER Philip Henry ADDRESS 2016 Oliver

Spec.—2-29-28—L. F. S.—500 Bks.

E 44894

HEALTH DEPARTMENT—CITY OF BALTIMORE

14-01

E 44894

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3719 E. Lombard ST., 26 WARD)

2—FULL NAME Lula May Gessner

(a) RESIDENCE NO. 3719 E Lombard ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm P. Gessner

6 DATE OF BIRTH (month, day, and year) May 13/86

7 AGE: Years 42 | Months 10 | Days 26 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

10 NAME OF FATHER Joseph Mahler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Susanna

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

Informant Wm P. Gessner

(Address) 3719 E Lombard

Filed 9-1929, 19

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8/29

17 I HEREBY CERTIFY, That I attended deceased from April 3 - , 1929, to April 8 , 1929.

that I last saw h alive on April 8, , 1929

and that death occurred, on the date stated above, at 10 50 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage.

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) Allen Bertram M. D.

4-8, 1929 (Address) 3139 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn

DATE OF BURIAL 4/11 1929

20 UNDERTAKER Philip Herring

ADDRESS 2016 Eutaw St

Spec.—1-10-21—M&T—1500 Bks.

44895

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

29 E 44895

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 315 S. Carey ST. (WARD) 18-29

2-FULL NAME John R Ellers

(a) RESIDENCE NO. 315 S. Carey ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Dan R Ellers

6 DATE OF BIRTH (month, day, and year) June 27 1859

7 AGE — Years: 70 Months: 9 Days: 16 If LESS than 1 day, hrs. or min.: 17.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Engineer

(b) General nature of industry, business, or establishment in which employed (or employer): 30 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Queen Annes Co Md

PARENTS

10 NAME OF FATHER James Ellers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Amanda Higgins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Walter Ellers

(Address) 2418 W Baltimore St

Filed 4-9-1929 H. HAMPSON JONES, M. D. Registrar

Ent. [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8 1929

17 I HEREBY CERTIFY, That I attended deceased from Feby 10, 1929, to April 8, 1929, that I last saw him alive on April 7, 1929, and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. O'Neill M. D.

4/8, 1929 (Address) 108 N Dulaney Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem DATE OF BURIAL: Apr 10 1929

20 UNDERTAKER: J. J. Cowan & Son ADDRESS: 901 [illegible]

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44896

CERTIFICATE OF DEATH

124 N

REGISTERED NO. **E 44896**

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hospital ST. [illegible] WARD)

2—FULL NAME Mary Priller

(a) RESIDENCE NO. Pennington Ave & Curtis Bay ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. 4 mos. 24 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Wh G

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of Martin J Priller

6 DATE OF BIRTH (month, day, and year): Nov 15 1884

7 AGE: Years 44 | Months 4 | Days 24 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md.

10 NAME OF FATHER: August Fabish

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Hankoff

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mr. Martin J Priller
(Address) Pennington Ave Curtis Creek

15 Filed APR 9 - 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/8/29

17 I HEREBY CERTIFY, That I attended deceased from 4/2, 19 29, to 4/8, 19 29, that I last saw h[illegible] alive on 4/8, 19 29 and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Acute Emphysema
of Gall Bladder
Acute (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia
(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 4/[illegible]/29

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) F. J. Wilkes, M. D.

, 19 (Address) Balto City Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross a.a.co md — DATE OF BURIAL: April 11 1929

20 UNDERTAKER: John F Denny — ADDRESS: 715 Light St

Spec.—2-29-28—L. F. S.—500 Bks.

E 44897 HEALTH DEPARTMENT—CITY OF BALTIMORE 100-001 E 44897

CERTIFICATE OF DEATH

1—PLACE OF DEATH Balto City Hospls REGISTERED NO.

CITY OF BALTIMORE: (No. Balto Md ST. 17-16 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Spriggs or Napoleon Bonaparte Spriggs

(a) RESIDENCE NO. 751 George St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 0.D

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Balto City Hospls
(Address) Balto Md

15 APR 9 1929 HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-5-29

17 I HEREBY CERTIFY, That I attended deceased from 4-1, 1929 to 4-5, 1929

that I last saw him alive on 4-5, 1929

and that death occurred, on the date stated above, at 5.10 P. m.

The CAUSE OF DEATH* was as follows:

Acute Alcoholic Delirium

Terminal Broncho Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Harry Goodman, M. D.

4/6, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem DATE OF BURIAL 4/9 1929

UNDERTAKER Samuel Wensley & Bro ADDRESS 75 E

Spec.—2-29-28—L. F. S.—500 Bks.

Dr Mpregatory 6 90

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44898

CERTIFICATE OF DEATH

E 44898

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 604 McCabe Ave ST. 27-28 WARD)

2—FULL NAME Beulah E Davidson

(a) RESIDENCE NO. 604 Mc Cabe Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John E Davidson

6 DATE OF BIRTH (month, day, and year) Nov. 14, 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	4	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer) House Work.

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Dorchester Co. Md.

10 NAME OF FATHER John W Riggins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dorchester Co Md

12 MAIDEN NAME OF MOTHER Susan J Hutchins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dorchester Co Md

14 Informant John E Davidson
(Address) 604 mc Cabe Ave.

15 Filed APR 9 1929 19 Registered

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) April 8/29

17 I HEREBY CERTIFY, That I attended deceased from March 23rd, 19 29, to April 8th, 19 29

that I last saw h.r alive on April 1st, 19 29

and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilitation

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Endocarditis.

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam

(Signed) Geo Wyndham Hill M. D.

(Address) 401 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL 4/10 1929

UNDERTAKER William Cook

ADDRESS 12 S Paul

HEALTH DEPARTMENT--CITY OF BALTIMORE

44899 1 PLACE OF DEATH

CERTIFICATE OF DEATH

100 001

E 44899

REGISTERED NO. C

CITY OF BALTIMORE (No. Old Fred Rd. Sta 20 28 ST.: 71 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Chas albert Shrumbler Jr

(Residence in Baltimore: No. Old Fred Rd + attol ave St.: yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word): Single

6 DATE OF BIRTH: April 28, 1927 (Month) (Day) (Year)

7 AGE: 1 yrs. 11 mos. 19 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): Baltimore Co Md

PARENTS

10 NAME OF FATHER: Chas albert Shrumbler

11 BIRTHPLACE OF FATHER (State or country): Md

12 MAIDEN NAME OF MOTHER: Anna Mary J Hale

13 BIRTHPLACE OF MOTHER (State or country): Balto Co Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs J S Hale
(Address) Balto Md Sta 20

15 Filed APR 9 1929 19 C. HAMPSON JONES, M. D. REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: April (Month) 8 (Day), 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from March 31, 1929, to April 8 1929, that I saw h[illegible] alive on April 8, 1929, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(Duration) — yrs. — mos. 7 ds

Contributory (SECONDARY) Meningites

(Duration) yrs. mos. 4 ds.

(Signed) Marshall B Wirt M. D.

April 8, 1929 (Address) Catonsville Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Salem Cemetery — DATE OF BURIAL: 4.10 .1929

20 UNDERTAKER: W. Cook — ADDRESS: 1217 E Cold St

IS VERY IMPORTANT. See instructions on back of certificate.

Cor.—1-12-23—M&T—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44900 E 44900

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Stone Fremont St., 17 WARD

REGISTERED NO. 1802

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis G. LeFevre

(a) RESIDENCE No. 605 Fondbourne Rd WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of W. G. LeFevre

6 DATE OF BIRTH (month, day, and year) 6-12-71

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	9	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housemoter

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer at Home

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Louis G. Fevre

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ft. Pa

12 MAIDEN NAME OF MOTHER Louise Dreker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ford

14 Informant Mrs L LeFevre

(Address) 605 Fondbourne

15 Filed 1923 C. HAMPSON JONES, M. D., Registrar.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/6 1923

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured skull, Accidental Injuries

Street Car - Accident

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Thos J Mowbray, M. D.

(Coroner.)

4/6, 1923 (Address) 2432 Roland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Presbyterian Woods DATE OF BURIAL 4/10 1923

20 UNDERTAKER W. M. Cook ADDRESS 1217 E. Fayette

Spec.—1-12-23—M&T—500 Bks.

E 44901 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

E 44901

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No. 25-32 ST. WARD)

2-FULL NAME Glenn Conway

(a) RESIDENCE NO. Cherry Hill ST. Hanover St & Brady WARD A III

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie Chaney

6 DATE OF BIRTH (month, day, and year) May 26 1893

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	10	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cambridge Md

PARENTS

10 NAME OF FATHER James Conway

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cambridge Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs. Carrie Conway (Address) Cherry Hills.

15 [illegible] HAMPSON JONES, M. D. Registrar

APR 9 - 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/8 1929

17 I HEREBY CERTIFY, That I attended deceased from 4/2, 1929, to 4/8, 1929, that I last saw him alive on 4/8, 1929, and that death occurred, on the date stated above, at 3:30 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) H. S. Rubinstein, M. D.

, 19 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery DATE OF BURIAL 4/9 1929

20 UNDERTAKER Margaret G. Flynn ADDRESS 1422 Light St

Spec.—2-29-28—L. F. S.—600 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44902

CERTIFICATE OF DEATH

× 100-001

E 44902

1—PLACE OF DEATH

REGISTERED NO. 33

CITY OF BALTIMORE: (No. So. Balto. Gen. Hosp. ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Catherine Brix

(a) RESIDENCE NO. Woodlawn Hts, Md. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life mos. 1 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed, or Divorced~~ (write the word)
Female	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

DATE OF BIRTH (month, day, and year) April 7, 1929

AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	2	

OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

BIRTHPLACE (city or town) (State or country) Woodlawn Hts, Md.

10 NAME OF FATHER William Brix

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Katherine Waglem

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

Informant William Brix

(Address) 713 S Ellwood Ave

Filed C. HANSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/9/29

17

I HEREBY CERTIFY, That I attended deceased from 4/8, 19 29, to 7/9, 19 29,

that I last saw h[illegible] alive on 7/9, 19 29

and that death occurred, on the date stated above, at 12:45 a m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. H. Fouthuesen, M. D.

7/9, 19 29 (Address) So. Balto. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	April 10 1929
20 UNDERTAKER Balt. F. Turner etc	ADDRESS 1742 N Broadway

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44903

CERTIFICATE OF DEATH.

84 E 44903

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 11 E. Chase ST. 11-15 WARD)

2-FULL NAME Ellen Salisbury Sterling

(a) RESIDENCE No. 11 E Chase ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 50 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Yates Sterling

6 DATE OF BIRTH (month, day, and year): Oct 3, 1843

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
85	6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Key West Florida

PARENTS

10 NAME OF FATHER: Salisbury Hayley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maine

12 MAIDEN NAME OF MOTHER: Mary De Burgo Maidonell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): St Augustine Florida

14 Informant: Miss Helen Sterling
(Address): 11 E Chase St

15 Filed Apr 10 1929 C. Hampson Jones, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 8 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 1928 to April 1929, that I last saw h alive on April 8 1929, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary oedema
(duration) ... yrs. ... mos 1 ds.
CONTRIBUTORY (Secondary) Cerebral Sclerosis
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? One trip

Did an operation precede death? No Date of ...

Was there an autopsy? No What test confirmed diagnosis? Signs & Symptoms

apha Howard Buckler, M. D.
1929 (Address) 806 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: National Cemetery Fort Meyer Va — DATE OF BURIAL: April 10 1929

20 UNDERTAKER: John B. Spence — ADDRESS: 1325 N Carolina St

Spec.—1-12-23—M&T—500 Bks.

E 44904 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 86 E 44904

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2160 Hollins (ST.) 40-64 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kate Murphy

(a) RESIDENCE NO. 2160 Hollins ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Nicholas Murphy

6 DATE OF BIRTH (month, day, and year): March 30 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
77	77		8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Patrick Malone

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: James J. Murphy (Address) 2160 Hollins St

15 Filed: 4-9-1929 C. H. HAMPSON JONES, M. D. Registrar Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/8 1929

17 I HEREBY CERTIFY, That I attended deceased from 4/1 1929 to 4/8 1929

that I last saw h[illegible]live on 4/8 1929

and that death occurred, on the date stated above, at 5.30 A.m.

The CAUSE OF DEATH* was as follows:

Cerebral Sclerosis Hypertension

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood pressure

(Signed) Chas A Carlson, M. D.

4/8, 1929 (Address) 2105 N Bolton St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Peters — DATE OF BURIAL: April 11 29

20 UNDERTAKER: Chas A Fields — ADDRESS: 1200 W Fayette

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44905 E 44905

CERTIFICATE OF DEATH

129

1—PLACE OF DEATH

REGISTERED NO. 70-64

CITY OF BALTIMORE: (No. 2125 N. Baltimore ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie M. Gibbs

(a) RESIDENCE NO. 2125 N. Baltimore ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William C. Gibbs

6 DATE OF BIRTH (month, day, and year): April 6-186[illegible]

7 AGE: Years 68 | Months — | Days 2 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home Duties

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: George H. Bowers

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Martha Norton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Lillie M. Tanzenfeldt

(Address): 2125 N. Baltimore St.

15 Filed [illegible] 9-1929 C. HAMPSON JONES, M.D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 8 29

17 I HEREBY CERTIFY, That I attended deceased from Mar 28, 1929, to April 8, 1929, that I last saw h[illegible] alive on April 8, 1929, and that death occurred, on the date stated above, at 8:30 [illegible] m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): Nephritis (duration) about one year

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Palm Thomas, M. D.

4/9, 1929 (Address) 1917 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park. DATE OF BURIAL: April 10, 1929

20 UNDERTAKER: [illegible] John H. Taylor & Son ADDRESS: 811 W. Fayette

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44906 161-001 **E 44906**

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1209 N. Caroline St., 8-13 Ward)

2-FULL NAME Infant Laugmead ✕ 1 Twin

(a) RESIDENCE NO. 1209 N. Caroline St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): April 8, '29

7 AGE — Years | Months | Days | IF LESS than 1 day ....hrs. or 15 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town): Balto Md.

(State or country)

PARENTS

10 NAME OF FATHER: Albert E Laugmead

11 BIRTHPLACE OF FATHER (city or town): Balto Md

(State or country)

12 MAIDEN NAME OF MOTHER: Eva M Vanhorn

13 BIRTHPLACE OF MOTHER (city or town): Balto Md

(State or country)

14 Informant: Albert E Laugmead

(Address) 1209 N. Caroline St.

15 Filed ....., 19.... HAMPSON Registrar

3464 C.M.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 8 1929

17 I HEREBY CERTIFY, That I attended deceased from April 8, 1929, to April 8, 1929, that I last saw him alive on April 8, 1929, and that death occurred, on the date stated above, at 12.30 p.m.

The CAUSE OF DEATH* was as follows: Premature about 6 mos.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. L. Frank M. D.

, 19 (Address) 2704 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND Date of Burial 19

20 UNDERTAKER: Commissioner Health ADDRESS

APR 9

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44907 — 167-001 — E 44907

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1209 N Caroline St. 8-13 Ward)

2-FULL NAME Infant Langmead & 2 Twins

(a) RESIDENCE NO. 1209 N Caroline St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): April 8 '29

7 AGE — Years | Months | Days | IF LESS than 1 day ..... hrs. or 15 mln.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Albert E. Langmead

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Eva M Van Horn

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Albert E Langmead (Address) 1209 N Caroline St

15 Filed APR 9 - 1929 C. HAMPSON 3465 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8 1929

17 I HEREBY CERTIFY, That I attended deceased from April 8, 1929, to April 8, 1929, that I last saw h__ alive on April 8, 1929, and that death occurred, on the date stated above, at 12.45 P. m.

THE CAUSE OF DEATH* was as follows:

Premature

about 6 mos.

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) ___

(duration) ___ yrs. ___ mos. ___ ds.

18 Where was disease contracted if not at place of death? ___

Did an operation precede death? ___ Date of ___

Was there an autopsy? ___

What test confirmed diagnosis? ___

(Signed) H. L. Starr, M. D.

, 19 (Address) 2704 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND — Date of Burial 19 APR 9 - 1929

20 UNDERTAKER — ADDRESS

Registrar

Spec.—2-29-28—L. F. S.—500 Bks.

E 44908

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 44908

31

1—PLACE OF DEATH

REGISTERED NO. 4718

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST., (C.H.) WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Reddick

(a) RESIDENCE NO. 1704 N. Spring st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Lilly M.

6 DATE OF BIRTH (month, day, and year) 1894

7 AGE 35	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(r) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) North Carolina

10 NAME OF FATHER Noah Reddick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records

(Address)

Filed Apr 9 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7, 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec. 15, 1928 to April 7, 1929

that I last saw him alive on April 7, 1929

and that death occurred, on the date stated above, at 5.15 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculous empyema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical and lab.

(Signed) Henry C. Smith, M. D.

4-8-, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
UNIVERSITY OF MARYLAND	APR 9- 1929
UNDERTAKER Commissioner Health.	ADDRESS

Spec. No. 5. 5000 Bks.

Spec.—2-29-28—L. F. S.—500 Bks.

E 44909

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44909

CERTIFICATE OF DEATH

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS

REGISTERED NO. 38

CITY OF BALTIMORE: (No. [redacted] ST. [redacted] WARD) 22-30

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edward Claggert

(a) RESIDENCE NO. 508 W. Lee ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? —yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Salusbury Claggert

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Maryland

12 MAIDEN NAME OF MOTHER Clino ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Maryland

14 Informant Records of (Address) BALTIMORE CITY HOSPITALS

15 Filed [illegible], 19[illegible] 346 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3, 1929

17

I HEREBY CERTIFY, That I attended deceased from March 27, 19 29, to April 3, 19 29,

that I last saw him alive on April 3, 19 29

and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic, Emphysema

Syphilis

(duration) over yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia. Bilateral

(duration) yrs. over mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? X-ray, Wassermann test, P.E.

(Signed) John E. Mann, M. D.

19 [illegible], 19[illegible] (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
UNIVERSITY OF MARYLAND	19
20 UNDERTAKER [redacted] Commissioner Health.	ADDRESS APR 9 1929

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44910 E 44910

CERTIFICATE OF DEATH

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO. 90

CITY OF BALTIMORE: (No. [redacted] ST., 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Wright

(a) RESIDENCE NO. 310 Forrest ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Levy Hemsley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Eliza ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Records of (Address) BALTIMORE CITY HOSPITALS UNIVERSITY

15 Filed APR 9 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 4, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 2, 1929 to April 4, 1929 that I last saw her alive on April 4, 1929 and that death occurred, on the date stated above, at 1:30 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Anemia secondary Enlarged Heart

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) John E. Moran, M. D.

19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND — DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health. — ADDRESS APR 9 - 1929

Cor.—10-10-29—A Co.—100 Bks.

E 44911

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 44911

90

24-35

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1437 Decatur St. St.) (Ward)

2-FULL NAME Edward V. Higdon.

(a) RESIDENCE NO. 1437 Decatur St. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. 1 mos. 23 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed or divorced, HUSBAND of Anna F. Higdon.

6 DATE OF BIRTH (month, day, and year) February 15, 1884

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	45	1	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Boiler maker.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Henry Higdon.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Senovia Peck.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore, Md.

14 Informant Senovia Anna F. Higdon.
(Address) 1437 Decatur St.

15 Filed 1929 C. HAMPSON JONES, M. D. Registrar
By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8, 1929.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Acute dilatation of the Heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ----

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? History.

(Signed) X, M. D.

4/8, 1929 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	4/11 1929
20 UNDERTAKER	ADDRESS
Eastern Ave	E. Mead St.

Important: See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 44912

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

54

E 44912

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS

REGISTERED NO.

CITY OF BALTIMORE: (No. [redacted] ST. 7-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Fountain L Pilcher

(a) RESIDENCE NO. 1205 Wash. Boulevard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. mos. ds. How long in U. S., if foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Pilcher

6 DATE OF BIRTH (month, day, and year) March 13 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61	—	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer None

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER James Pilcher

11 BIRTHPLACE OF FATHER (city or town) Harpers Ferry
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town) Harpers Ferry
(State or country) Md

14 Informant [illegible] (Address) [illegible] Records (Relative) (Friend) (Daughter)

BALTIMORE CITY HOSPITALS

15 Filed [illegible], 1929 C. HAMPSON JONES, M. D.
Registrar

9-1929 By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-8-29

17 I HEREBY CERTIFY, That I attended deceased from 2-9, 1929, to 4-8, 1929, that I last saw h[illegible] alive on 4-8, 1929 and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Pellagra

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis; Cachexia; Myocarditis, chr (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Marvin M. McClean, M. D.

, 19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill

DATE OF BURIAL 4/10 1929

20 UNDERTAKER W. M. Cook

ADDRESS 1214 E Fond St

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44913

CERTIFICATE OF DEATH

37 E 44913

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 6-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arney Blizzard

(a) RESIDENCE. NO. 125 N. Rose St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7/ yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 6. 1927

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	1	11	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Orphan

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER Virgil Blizzard

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Esthy Bell

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Virgil Blizzard

(Address) 125 N Rose St

15 Filed APR 7-1929 C. HAMPSON JONES, M. D. Registrar

Par.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/9/29 19

17 I HEREBY CERTIFY, That I attended deceased from 4/6/29, 19, to 4/9/29, 19, that I last saw him alive on 4/9/29 19, and that death occurred, on the date stated above, at 2 50 PM m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) yrs 3 to 5 mos. ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos 3 da.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) J. E. Whitehead, M. D.

. 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel — Date of Burial 4/11 1929

20 UNDERTAKER W. M. Cook — ADDRESS 1217 E Pratt St

Very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Dr Nublet 2220 Garrison Blvd

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44914

CERTIFICATE OF DEATH

E 44914

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 4607 Towonda Ave ST. 15-56 (WARD)

2—FULL NAME Edward N. Nichols Sr

(a) RESIDENCE NO. 4607 Towonda Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Agnes L Nichols

6 DATE OF BIRTH (month, day, and year) Dec 11, 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
61	62	3	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession of particular kind of work Auditor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer U.S.F.&G. Co

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Dudley Nichols

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Martha E Vaughn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Agnes Nichols

(Address) 4607 Towonda Ave

15 Filed ....., 19.... C. HAMPSON JONES, M.D. Registrar

Par. Apr

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 7, 1929

17 I HEREBY CERTIFY, That I attended deceased from Apr 1, 1929, to Apr 7, 1929, that I last saw him alive on Apr 6, 1929 and that death occurred, on the date stated above, at 1:30 a.m.

The CAUSE OF DEATH* was as follows:

Encephalitis (non Epidemic) from history duration about 2 wks (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Encephalitis duration about 2 wks (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Walter S Nublett, M. D.

Apr 8, 1929 (Address) 2220 Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount	4 10 1929
20 UNDERTAKER	ADDRESS
Wm Cook	2124 Pennsylvania Ave

Spec.—12-9-25—A Co.—200 Bks.

44 44915

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 44915

REGISTERED NO.

1-PLACE OF DEATH Church Home & Inf.

City of BALTIMORE: (No. Broadway & Fairmount St. 6-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Achsah Johnson

(a) RESIDENCE NO. Ellicott City, Md. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 7 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 1857

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	72	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dress Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Ellicott City

(State or country) Maryland

PARENTS

10 NAME OF FATHER Anthony M. Johnson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Pa

12 MAIDEN NAME OF MOTHER Josephine Dorsey

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Lee Johnson

(Address) Ellicott City

Filed ..... 19 ..... C. HARRISON JONES, M. D. Registrar

A 101929 Par. [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9, 1929 19

17

I HEREBY CERTIFY, That I attended deceased from April 2, 1929, to April 9, 1929

that I last saw h.er alive on April 9, 1929

and that death occurred, on the date stated above, at 9:45 p.m.

The CAUSE OF DEATH* was as follows:

Cardiac Decompensation

Arteriosclerosis

Myocarditis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Senility

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Walter B. Johnson, M. D.

, 19 (Address) Church Home & Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Johns Cemetery Date of Burial April 11 1929

20 UNDERTAKER Scott M. Starr ADDRESS Ellicott City Md

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44916

CERTIFICATE OF DEATH

E 44916

REGISTERED NO. 2697

1-PLACE OF DEATH

City of BALTIMORE: (No. 1904 McCulloh St. 11-34 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adella L. Taylor

(a) RESIDENCE NO. 1904 McCulloh St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred // yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
female	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 15, 1894

7 AGE Years	Months	Days	IF LESS than 1 day ...hrs. or ...min..
34	8	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work, Waitress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Danville Ky.

(State or country)

PARENTS

10 NAME OF FATHER Lee M Clark

11 BIRTHPLACE OF FATHER (City or town) Danville Ky

(State or country)

12 MAIDEN NAME OF MOTHER Susie E. Isaacs

13 BIRTHPLACE OF MOTHER (city or town) Danville

(State or country)

14 Informant (Address) 1904 McCulloh St Susie Isaacs

APR 10 1929 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 23, 1929, to April 9, 1929, that I last saw h[er] alive on April 3, 1929, and that death occurred, on the date stated above, at 4:15 A m.

The CAUSE OF DEATH* was as follows:

Acute Pneumonia

Tuberculosis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Microscopical Exam

(Signed) M. Edwalle, M. D.

, 19 (Address) 112 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

Date of Burial 4-10 1929

20 UNDERTAKER David Easton

ADDRESS 916 Pa Ave

Very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44917

CERTIFICATE OF DEATH

E 44917

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 560 W. Preston St., 17-2 Ward)

2-FULL NAME Emory L. Hall

(a) RESIDENCE NO. 560 W. Preston Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mollie Hall

6 DATE OF BIRTH (month, day, and year) June 16 1888

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	40	9	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Emory L Hall

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Mary Thomas

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Mollie Hall
(Address) 560 W. Preston

Filed [illegible] 19 [illegible] Registrar

R 10 1929 C. HAMPSON JONES, M. D.

Per [illegible]

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) April 8th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) ? yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. C. Smith, M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Natl Grad Gdns. — DATE OF BURIAL 4-9-29

20 UNDERTAKER Daniel Cayard — ADDRESS 916 Pa ave.

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 44918 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 44918

CERTIFICATE OF DEATH

187-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Church Home & Infirmary St., 6-11 Ward)

2-FULL NAME Jennie Schweiger

(a) RESIDENCE NO. 207 N. Streeper St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Schweiger

6 DATE OF BIRTH (month, day, and year) Oct. 3 1869

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	59	6	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Pancratius Deinlein

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Mary K. Stuppler

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Mr. John Schweiger
(Address) 207 N. Streeper St

15 Filed 10-19-29 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 8/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock- Multiple injuries accidently fell down elevator shaft at Church Home & Infirmary (duration) yrs. mos. 1/2 hr ds.

CONTRIBUTORY (Secondary) Gastric Carcinoma?- Pyo-carditis (duration) several yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? History & examination

(Signed) J. H. Mellen, M. D.

4/9/29 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	April 10 1929
20 UNDERTAKER	ADDRESS
Jos. J. Herr & Son	156 N. Eutaw

Important. See instructions on back of certificate.

101929

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44919

CERTIFICATE OF DEATH.

90 E 44919

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1707 E. Chase ST. 7-12 WARD)

2-FULL NAME Elizabeth Dean

(a) RESIDENCE NO. 1707 E. Chase ST., ... WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George A Dean

6 DATE OF BIRTH (month, day, and year): 12/2/1850

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
78	4	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: John Devlin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Elizabeth Devlin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Michael Dean (Address) 1707 E Chase St

15 FILED 10 1929 C. HARRISON JONES, M. D. Registrar Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 8 1929

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1929, to April 8, 1929, that I last saw her alive on April 7, 1929, and that death occurred, on the date stated above, at 8.50 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) ... yrs. mos. ds.

CONTRIBUTORY (Secondary): Oedema of Lungs

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm J. Schmit, M. D.

4-9 1929 (Address) 701 N. Richmond Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem — DATE OF BURIAL: 4/11 1929

20 UNDERTAKER: George J Ruth — ADDRESS: 1735 Harford Ave

Spec.—2-29-28—L. F. S.—500 Bks.

E 24085
E 44920

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001

E 44920

1—PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 9-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harry Flautt

(a) RESIDENCE NO. 1812 N. Caroline ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) 9/4 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	7	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

10 NAME OF FATHER Harry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Evelyn Livingstone

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

R101929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 5th, 1929, to April 9, 1929, that I last saw h[illegible] alive on April 9, 1929, and that death occurred, on the date stated above, at 1230 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home do

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? X-ray

(Signed) V. C. Jacobson, M. D.

4/9, 1929 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	4/12/1929
20 UNDERTAKER George J. Ruth 1735	ADDRESS Harford Ave

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44921

CERTIFICATE OF DEATH.

E 44921
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Gralbert Apt 15-68 St. Ward)

2-FULL NAME Sarah Engel

(a) RESIDENCE NO. 2037 n mont St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Abraham Engel

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE: Years 65 Months — Days — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Work
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town): Russia
(State or country)

PARENTS

10 NAME OF FATHER: J. Lehman

11 BIRTHPLACE OF FATHER (city or town): Russia
(State or country)

12 MAIDEN NAME OF MOTHER: [illegible]

13 BIRTHPLACE OF MOTHER (city or town):
(State or country) Russia

14 Informant: A Engel
(Address) 2037 n mont

15 Filed [illegible] 19 [illegible] C. HAMPSON JONES, M. D. Registrar

R101529

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 9, 29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lupus Pulmonalis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

Apr 10 Signed: [illegible] M. D.
(Coroner)
19 29 Address: 1654 Bon

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the state yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship

Date of Burial 4/ 19 29

20 UNDERTAKER: Jack Levis ADDRESS 1409 E Balto St

Spec. –7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44922

CERTIFICATE OF DEATH

117

E 44922

1-PLACE OF DEATH Md. Gen. Hosp. REGISTERED NO.

City of BALTIMORE: (No. 20-69 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Lee Kunkel

(a) RESIDENCE NO. 2739 A. Fairmount Ave Ward
(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. 7 mos. 15 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of William Fredrick Kunkel

6 DATE OF BIRTH (month, day, and year) Sept 25 1911 Balto

7 AGE 17 Years 7 Months 15 Days IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work H. Wife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto, Md.
(State or country)

PARENTS

10 NAME OF FATHER Robert Lee Mercier

11 BIRTHPLACE OF FATHER (City or town) Balto Md
(State or country)

12 MAIDEN NAME OF MOTHER Margaret Winifred McComack

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Hospital Record
(Address)

Filed 1929 HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-9-1929

17 I HEREBY CERTIFY, That I attended deceased from 4-1-1929, to 4-9-1929, that I last saw h.. alive on 4-9-1929, and that death occurred, on the date stated above, at 3.40 P m.

The CAUSE OF DEATH* was as follows:

Ruptured Ovarian Cyst (Rt)
Chronic Appendicitis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Paralytic Ileus

(duration) yrs. mos 3 ds.

18 Where was disease contracted if not at place of death? At Home
Did an operation precede death? Yes Date of 4-2-29
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) Jno Grampa Jones M.D.
4/9/1929 (Address) Mt Vernon Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery Date of Burial Apr 12 1929

20 UNDERTAKER Jos Joerdens Son ADDRESS 2172 Pa...

Very Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44923

CERTIFICATE OF DEATH

90

E 44923

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1021 Harlem Ave ST. 16-23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Magalene Hall

(a) RESIDENCE NO. 1021 Harlem Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Negro	Widow

a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm N. Hall

6 DATE OF BIRTH (month, day, and year) Nov 11- 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	4	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unemployed

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Magothy Md.

10 NAME OF FATHER Geo. Edwards

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Owens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Samuel D. Hall

(Address) 1021 Harlem Ave.

15 APR 10 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-7- 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb. 9th. 1929 to April 7, 1929

that I last saw her alive on April 5th. 1929

and that death occurred, on the date stated above, at 8; 30 p. m.

The CAUSE OF DEATH* was as follows:

Cardiac Decompensation

(duration) 0 yrs. 6 mos. 26 ds.

CONTRIBUTORY (Secondary) Aortic Ins.

(duration) 1 ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Exam.

(Signed) Walter J. Jackson, M. D.

19 (Address) 1631 W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Magothy	4/10 1929
20 UNDERTAKER Samuel Kennedy	ADDRESS 1728 N Bradford St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44924

CERTIFICATE OF DEATH.

101

E 44924

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2818 Riggs av S. 16-68 WARD)

2-FULL NAME Sallie E Thursby

(a) RESIDENCE NO. 2818 Riggs ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	M.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert A Thursby

6 DATE OF BIRTH (month, day, and year) Oct 14 52

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	76	5	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or estahlishment in which employed (or einployer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Jordan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER " "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

14 Informant Mrs E S Moore

(Address) 2818 Riggs av

15 Date APR 10 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 9 1929

17 I HEREBY CERTIFY, That I attended deceased from April 2, 1929, to Apr. 9, 1929, that I last saw h[illegible] alive on Apr. 8, 1929, and that death occurred, on the date stated above, at 8.10 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia,

(Left Upper)

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? Clinical

(Signed) J Wesley Call, M. D.

9/10. 1929 (Address) 2202 Garrison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Park Cem

DATE OF BURIAL April 11 1929

20 UNDERTAKER W M Poulton

ADDRESS 2258 N Mtb

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44925

CERTIFICATE OF DEATH

24001

E 44925

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1413 Webster st ST. 24-33 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Caroline W. Hartlove

(a) RESIDENCE NO. 1413 Webster St ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: John B. Hartlove

6 DATE OF BIRTH (month, day, and year): Feb. 5 1854

7 AGE — Years: 75 | Months: 2 | Days: 3 | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): germany

10 NAME OF FATHER: John Bailey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs Frederick Hartlove

(Address): 1413 Webster St

15 Filed 19 Registrar: C. HAMPSON JONES, M.

R 101923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-8-29

17 I HEREBY CERTIFY, That I attended deceased from Mar 15, 1929, to April 8, 1929, that I last saw h alive on April 8, 1929, and that death occurred, on the date stated above, at 12 00 Noon

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 24 ds.

CONTRIBUTORY (Secondary): Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. L. Campbell, M.D.

4/9, 1929 (Address) 1644 Linwood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery

DATE OF BURIAL: 4/11 1929

20 UNDERTAKER: L. Frew McCully

ADDRESS: 130 E Fort

Spec.—2-29-28—L. F. S.—500 Bks.

2239 E/44926

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 44926

1—PLACE OF DEATH Johns Hopkins Hospital

CITY OF BALTIMORE: (No.) ST. 3-d WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Samuel Kluska

(a) RESIDENCE NO. 306 S. Carolina St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) unk

7 AGE: Years 39; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

10 NAME OF FATHER John Klutza

11 BIRTHPLACE OF FATHER (city or town) Poland (State or country)

12 MAIDEN NAME OF MOTHER Unk

13 BIRTHPLACE OF MOTHER (city or town) Poland (State or country)

Informant Records

(Address) Johns Hopkins Hospital

Filed APR 10 1929 HAMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8-29

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1929, to April 8, 1929, that I last saw h[illegible] alive on April 8, 1929 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

CONTRIBUTORY (Secondary) Myocardial Insufficiency (duration) — yrs. 3 mos. — ds.

18 Where was disease contracted if not at place of death? At home (duration) yrs. mos. ds.

Did an operation precede death? — Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Sidney I Gladstone, M. D.

19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary

DATE OF BURIAL: April 11 — 29 19

20 UNDERTAKER: F. W. Ozazewski

ADDRESS: 1930 Eastern Av

Spec.—2-29-28—L. F. S.—500 Blks.

E 44927 HEALTH DEPARTMENT—CITY OF BALTIMORE E 44927

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. St. Josephs Hosp ST., 9-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Florence E. Schussler

(a) RESIDENCE NO. Turners Station ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. 3 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Adam H. Schussler

6 DATE OF BIRTH (month, day, and year) Not Stated

7 AGE:	Years	Months	Days	If LESS than 1 day, hrs. or min.
About	53	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

10 NAME OF FATHER John Ables

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mr. Schussler

(Address) 1132 E Eager St

Filed 4-10-1929 HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 9-1929

17 I HEREBY CERTIFY, That I attended deceased from Apr. 6, 1929, to Apr. 9, 1929, that I last saw her alive on Apr. 9, 1929 and that death occurred, on the date stated above, at 10:25 a m.

The CAUSE OF DEATH* was as follows:

Chronic Bronchitis

(duration) Unk yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Singleton, M. D.

4-9-1929 (Address) St Josephs Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery Co	April 12 1929
20 UNDERTAKER Henry Hoech Sons, Inc.	ADDRESS 1301 E Eager St

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44928

CERTIFICATE OF DEATH

129 E 44928

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 430 n Carlton St. 6-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martina Berry

(a) RESIDENCE NO. 430 N Carlton St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: C

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Albert Berry

6 DATE OF BIRTH (month, day, and year): Unknown 1882

7 AGE: Years 46 Months Days

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer): Laundress

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant: Albert Berry

(Address) 130 n Carlton St

101929 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 8 1929

17 I HEREBY CERTIFY, That I attended deceased from April 7. 1929 to April 8. 1929.

that I last saw h alive on April 8, 1929.

and that death occurred, on the date stated above, at 1 16 A m.

The CAUSE OF DEATH* was as follows:

Osteomyelitis Cerebral Mastoiditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonal Tuberculosis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Physical

(Signed) [illegible], M. D.

April 11 1929 (Address) 508 [illegible] Ave

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary Date of Burial Apr 10, 1929

20 UNDERTAKER: Mrs R. A. Elliott ADDRESS 1126 Eastland Ave

Very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44928

CERTIFICATE OF DEATH

5/ E 44929

1-PLACE OF DEATH Provident Hospital

CITY OF BALTIMORE: (No.) Balt. Md. (ST.) 10-13 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Florence Lee

(a) RESIDENCE No. 702 N Caroline ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Colored	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Va (State or country)

PARENTS

10 NAME OF FATHER Wm. Lee. ~~Unknown~~

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Wm Lee (Address) 917 N. Eutaw St.

15 Filed 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 8 1929

17 I HEREBY CERTIFY, That I attended deceased from March 5, 1929, to Apr 8, 1929, that I last saw h[illegible] alive on Apr 8, 1929, and that death occurred, on the date stated above, at 8 45 m.

The CAUSE OF DEATH* was as follows:

Cardiac Decompensation (Mitral Insufficiency)

(duration) yrs. 1½ mos ds.

CONTRIBUTORY (Secondary) Acute Rheumatic Fever

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Undetermined

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) M. Jackson, M. D.

4/9, 1929 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary

DATE OF BURIAL Apr 10, 1929

UNDERTAKER Wm. R. G. Elliott

ADDRESS 1725 Eastlander

Spec.—2-29-28—L. F. S.—500 Bks.

E 44930 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001 E 44930

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. St Joseph Hosp ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Arthur Page

(a) RESIDENCE NO. 1223 Madison Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	B	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible] 1894

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Chemical Co.

9 BIRTHPLACE (city or town) (State or country) Kansas City Missouri

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records

(Address)

15 [illegible], 19 [illegible] 1929 HAMPSON JONES, M.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 6, 1929

17

I HEREBY CERTIFY, That I attended deceased from 4-3, 19 29, to 4-6, 19 29.

that I last saw h[illegible] alive on April 6, 19 29

and that death occurred, on the date stated above, at 2.35 P m.

The CAUSE OF DEATH* was as follows:

Lobar ~~Pneumonia~~ Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Pulm Edema

(duration) yrs. mos. ½ ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? none

What test confirmed diagnosis? Clinical

(Signed) C. C. Cunningham, M. D.

, 19 (Address) St Joseph Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Calvary	Apr. 10, 1929
20 UNDERTAKER Mrs R. G. Elliott	ADDRESS 1725 Ashland Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44931

CERTIFICATE OF DEATH

90 E 44931

1—PLACE OF DEATH

REGISTERED NO. .....

CITY OF BALTIMORE: (No. 1739 orleans ST. 6-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thomas Bell

(a) RESIDENCE NO. 1739 orleans ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colord

5 Single, Married, Widowed, or Divorced, (write the word): Widower

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE — Years: 53 52 | Months: | Days: | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Labor

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Elizebeth Jones
(Address) 1739 orleans st

15 Filed 4/9/1929 HAMPSON JONES, M. D., Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7-29

17 I HEREBY CERTIFY, That I attended deceased from March 31, 29 to April 7, 1929, that I last saw h alive on April 7, 1929 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficency

Interval (duration) 6 yrs. 7 mos. 7 ds.

CONTRIBUTORY (Secondary) Cerebral Cirhosis

three days (duration) 0 yrs. 0 mos. 3 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) J. Edward Fisher, M. D.

April 9, 1929 (Address) 1612 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion cemetery — DATE OF BURIAL: April 10, 1929

20 UNDERTAKER: Edward Bryan — ADDRESS 1631 orleans st

Spec.—1-12-23—M&T—500 Bks.

E 44932

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74 001

E 44932

1-PLACE OF DEATH St. Agnes Hospital

CITY OF BALTIMORE: (No. Caton & Wilkens Aves ST. 25-72 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rt. Rev. Owen B Corrigan, DD.

(a) RESIDENCE NO St. Agnes Hospital ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clergyman.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Owen B Corrigan

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Mildred Murphy,

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Hospital Records.
(Address) St Agnes

15 Medical Examiner C. HARRISON JONES, M. D.
(Address)

RT 5 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-8 1929

17 I HEREBY CERTIFY, That I attended deceased from , 1929, to April 8, 1929, that I last saw h alive on April 8, 1929, and that death occurred, on the date stated above, at 1.20 A m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency.
Arteriosclerosis.

(duration) 6 yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage.

(duration) yrs. mos. 1 ds.

018

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Nicholas J Donnelly, M. D.

19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 4-11-29

UNDERTAKER Martin Tobey & Sons

ADDRESS 1827 North Ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44933

CERTIFICATE OF DEATH

REGISTERED NO. E 44933

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hosp St., 14-20 Ward)

2-FULL NAME Jas E. Chambers

(a) RESIDENCE NO. Glenelg Md St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. One ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 1869

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	60	1		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Robt Chambers

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Sarah Jones

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Elizah Hackett
(Address) Glenelg Md

Filed APR 10 1929 C. HAMPSON JONES, M. D. Registrar

By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) April 9th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Aortic Insufficiency

(duration) Three mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Physician
(Signed) Elmer Flickinger, M. D.
(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Co Mt. Evergreen

DATE OF BURIAL May 10 1929

20 UNDERTAKER Easton Bros

ADDRESS Ellicott City

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44934

CERTIFICATE OF DEATH

38 E 44934

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS [redacted] REGISTERED NO.

CITY OF BALTIMORE: (No. [redacted] ST. 16-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Wesley Johnson

(a) RESIDENCE NO. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) ----

(c) Name of employer ----

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country)

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Records of
(Address) BALTIMORE CITY HOSPITALS

15 Filed [redacted] G. HAMILTON JONES, M. D. Registrar

R101029

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4 - 7 -29

17 I HEREBY CERTIFY, That I attended deceased from 3-23 19 26, to 4-7 19 29,

that I last saw him alive on 4-7 19 29

and that death occurred, on the date stated above, at 2.15 P. m.

The CAUSE OF DEATH* was as follows:

Syphilis

(duration) 13 yrs. mos. ds.

CONTRIBUTORY (Secondary) See other side

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of --

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Warren W McClain, M. D.

, 19 (Address) BALTIMORE CITY HOSPITALS [redacted]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Disinterred and buried in Westminster Cem ERSITY OF MARYLAND

DATE OF BURIAL 4-13 1929

UNDERTAKER [redacted] Brown

ADDRESS 108 N Montgomery St

APR 10 1929

Spec.—1-12-23—M&T—500 Bks.

E 44935

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44935

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 504-S. Spring ST., 3rd WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daisy Owens

(a) RESIDENCE NO. 504-S. Spring ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	C	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas. Owens.

6 DATE OF BIRTH (month, day, and year) 1884.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Chas. Owens (Address) 504-S. Spring St

15 Filed 10 1929 19 Per H. Harrison Jones, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7th 1929

17 I HEREBY CERTIFY, That I attended deceased from April 7th, 1929, to April 8th, 1929, that I last saw her alive on April 7th, 1929 and that death occurred, on the date stated above, at 3:30 P.M.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Same

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jacob L. Wisner, M. D.

4-10, 1929 (Address) 30 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	4/10/29

20 UNDERTAKER Geo. J. Keith ADDRESS 1735 Harford Ave

Spec.—1-12-23—M&T—500 Bks.

E 44936 HEALTH DEPARTMENT—CITY OF BALTIMORE E 44936

CERTIFICATE OF DEATH. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2934 Westwood St., 15-67 Ward

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella A. Klinger

(a) RESIDENCE No. 2934 Westwood St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female. 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed.

5a If married, widowed, or divorced ~~HUSBAND of~~ or) WIFE of Samuel H. Klinger

6 DATE OF BIRTH (month, day, and year) Oct. 23 1865

7 AGE Years 63 Months 5 Days 15 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Windsor Md

PARENTS

10 NAME OF FATHER John G. Heist

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Trumbo

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs Louise Ely

(Address) 2934 Westwood Ave

Filed APR 10 1929 C. HAMILTON [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April. 8 1929

17 I HEREBY CERTIFY, That I attended deceased from July, 1919, to April. 8, 1929

that I last saw him alive on April. 5, 1929

and that death occurred, on the date stated above, at 11.40 P.M.

The CAUSE OF DEATH* was as follows:

Valvular Heart

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. R. Miller M. D.

4/9/29 (Address) 2757 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery DATE OF BURIAL April 12 1929

UNDERTAKER Josiah Syfer ADDRESS Govans, Md.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44937

100-001

CERTIFICATE OF DEATH

E 44937

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emma R. Schueler

(a) RESIDENCE NO. 1303 W. Lombard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 54 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6a If married, widowed, or divorced WIFE of: late Louis A. Schueler

6 DATE OF BIRTH (month, day, and year): Oct 10, 1869.

7 AGE: Years 59 | Months 5 | Days 27 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

10 NAME OF FATHER: Daniel Elliott

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Virginia Donohue

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Louis A. Schueler

(Address) 1303 W. Lombard St.

Filed OCT 10 1929, 19

HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/3/29

17 I HEREBY CERTIFY, That I attended deceased from 3/29, 19 29, to 4/3, 19 29

that I last saw her alive on 4/3, 19 29

and that death occurred, on the date stated above, at 3 15 p.m.

The CAUSE OF DEATH* was as follows:

Pyemia with multiple subcutaneous sites of metastatic infection

(duration) yrs. mos. 7 ds. †

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Charles E. Gill, M. D.

4/7, 19 29 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Apr 10 1929

20 UNDERTAKER: Harry H. Witzke — ADDRESS: 1531 W. Lombard St.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 44938 (1—PLACE OF DEATH)

90

E 44938 REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 332 Rossiter Ave ST. (Ward) 9th

2—FULL NAME Thomas O Blair

(a) RESIDENCE NO. Rossiter Ave ST., 332 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Annie Blair

6 DATE OF BIRTH (month, day, and year): Unknown.

7 AGE: Years 80 | Months — | Days — | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Ireland

10 NAME OF FATHER: Oliver Blair

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Ann Dilworth

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Charles T Blair

(Address) Kingsville Md

15 Filed ..... By HAMPSON JONES M.D. Registrar

R 101929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April-9-29.

17 I HEREBY CERTIFY, That I attended deceased from April-4-, 1928, to April-9-, 1929, that I last saw h— alive on April-8-, 1929, and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Myocardial Failure

..... (duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Senility

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) Marion W Thomas M.D.

(Address) 806 4 Fullerton Ave

4-9-29

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Johns Kingsville Md. DATE OF BURIAL: 4-11 1929

20 UNDERTAKER: David Davidson ADDRESS: Upperfalls Md.

Spec.—2-29-28—L. F. S.—500 Blks.

E 44939

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 44939

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

CITY OF BALTIMORE: (No. [redacted] ST. 6-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank Wallace

(a) RESIDENCE NO. 26 N. Durham ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married Sarah Wilmore Wallace

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
38				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

10 NAME OF FATHER Major Elsey

11 BIRTHPLACE OF FATHER (city or town) Deals Island (State or country) Md

12 MAIDEN NAME OF MOTHER Julia Dammel

13 BIRTHPLACE OF MOTHER (city or town) Northumberland Co (State or country) Va

14 Informant from Sister Records of BALTIMORE CITY HOSPITALS (Address)

15 Filed [illegible] 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8, 1929

17 I HEREBY CERTIFY, That I attended deceased from January 15, 1929, to April 8, 1929, that I last saw h. im alive on April 8, 1929 and that death occurred, on the date stated above, at 5.30 A. m.

The CAUSE OF DEATH* was as follows:

Hypocarditis chronic & acute, & enlargement & insufficiency

(duration) over 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis & Hypertension

Bronchopneumonia (duration) ? yrs. mos. da.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy & Physical Exam

(Signed) Marvin M. McClean, M. D.

19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	Apr. 12 1929
20 UNDERTAKER	ADDRESS
Chas. F. Johnson	416 N. Caroline St.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44940 ✓ E 44940

CERTIFICATE OF DEATH

90

1—PLACE OF DEATH

REGISTERED NO. 16-22

CITY OF BALTIMORE: (No. 724 N. Gilmor St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna Brown.

(a) RESIDENCE NO. 724 N. Gilmor ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Charles Brown

6 DATE OF BIRTH (month, day, and year): July 1887

7 AGE: Years 42 | Months 8 | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): N. C.

PARENTS

10 NAME OF FATHER: Peter Cox

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. C.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. C.

14 Informant: Charles F. Brown

(Address) 724 N. Gilmor St.

15 Date: 10-1929 C. HAMPSON JONES, M. D.

Per: Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr. 8-1929

17 I HEREBY CERTIFY, That I attended deceased from Apr. 26, 1929, to Apr. 8, 1929, that I last saw h.. alive on Apr. 8, 1929, and that death occurred, on the date stated above, at 3 30 P. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation & Heart

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis & Nephritis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptomatology

(Signed) W. S. Estell, M. D.

, 19 (Address) 924 Gilmor

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ashburn Cemetery

DATE OF BURIAL: Apr. 11 1929

20 UNDERTAKER: Chas. H. Johnson

ADDRESS: 446 N. Gilmor St.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44941

CERTIFICATE OF DEATH

129

REGISTERED NO. E 44941

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1530 Hollins ST., 19-28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Augustine Calanzaro

(a) RESIDENCE NO. 1530 Hollins ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec 23, 1864

7 AGE — Years: 64 — Months: 3 — Days: 15 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Storekeeper

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER: Augustine Calanzaro

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Anna Cuspura

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: Joseph Calanzaro

(Address) 510 Craig Ave

15 FILED APR 10 1929, C. HAMPSON JONES, M. D., Registrar

R 10 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr. 8, 1929

17 I HEREBY CERTIFY, That I attended deceased from 6/29, 1924, to 4/8, 1929, that I last saw h[illegible] alive on Apr. 8, 1929 and that death occurred, on the date stated above, at 5:50 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary): Uremia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) W. S. Dieseeto, M. D.

, 19 (Address) 134 W. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: Apr 11 1929

UNDERTAKER: Charles H Keehner — ADDRESS: Hollins

Spec.—2-29-28—L. F. S.—500 Blks.

E 44942

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 44942

1—PLACE OF DEATH University Hosp. REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 18 W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary A Jones

(a) RESIDENCE NO. 1214 W. Pratt St. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Stephenson Jones

6 DATE OF BIRTH (month, day, and year) July 1897-28

7 AGE: Years 51 | Months 8 | Days 11 | If LESS than 1 day, ___ hrs. or ___ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Lawrence Kerner

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary E Murphy

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore Md

14 Informant Stevens L Jones
(Address) 1214 W Pratt St

15 Filed ____, 19 ____ C. HAMPSON JONES, M. D. Registrar

FRIENDS

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9th 1929

17 I HEREBY CERTIFY, That I attended deceased from April 8th, 1929, to April 9th, 1929, that I last saw her alive on April 9th, 1929, and that death occurred, on the date stated above, at 2 30 A.m.

The CAUSE OF DEATH* was as follows:

Cardiac failure
Chronic myocarditis
abd. ascites, Chronic passive congestion (duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Pulmonary edema (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? 1214 W. Pratt St

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) EG Warner, M. D.

, 19 (Address) Univ Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	April 12 1929
20 UNDERTAKER Charles H Kechner	ADDRESS 1532 Hollins

E 44943

HEALTH DEPARTMENT--CITY OF BALTIMORE

CERTIFICATE OF DEATH

91-002 V

E 44943
REGISTERED No. C

1 PLACE OF DEATH

CITY OF BALTIMORE (No.) 717 St Paul ST. H-15 WARD)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Hannah H.C. Chase

(Residence in Baltimore: No. 717 St Paul

St.: 65 yrs. 11 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Widow

6 DATE OF BIRTH: March 31, (Month) (Day) 1850 (Year)

7 AGE: 79 yrs. mos. 10 ds. | If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): do

PARENTS

9 BIRTHPLACE (State or country): Baltimore Md.

10 NAME OF FATHER: Robt Chesborough

11 BIRTHPLACE OF FATHER (State or country): Conn.

12 MAIDEN NAME OF MOTHER: Hannah H

13 BIRTHPLACE OF MOTHER (State or country): Baltimore Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Philip W Chase
(Address) 3509 Derwyn Rd

15 Filed 4-11-1929 E. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: April 10th (Month) (Day), 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from Sept 14, 1928, to April 10 1929
that I saw h-e alive on April 9 1929
and that death occurred, on the date stated above, at 1,209 m.
The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(Duration) yrs. mos. 3 ds

Contributory (SECONDARY) Arteriosclerosis

(Duration) 8 yrs. mos. ds.

(Signed) H E Kyser M. D.
4-10-, 1929 (Address) Wilkens Heights

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
At place of death yrs. mos. ds. In the State yrs. mos. ds.
Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Green Mount Cem | DATE OF BURIAL: April 11, 1929

20 UNDERTAKER: Geo Small & Sons | ADDRESS 453 W Fayette

IS VERY IMPORTANT. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 44944 HEALTH DEPARTMENT—CITY OF BALTIMORE E 44944

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Women Hosp. REGISTERED NO. 90

CITY OF BALTIMORE: (No. 3135 ST. Wilkins Ave (WARD) 26-12

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Christina Jubb

(a) RESIDENCE No. 3135 Wilkins Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas W Jubb

6 DATE OF BIRTH (month, day, and year) Nov 7, 1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23	5	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER John Parlik

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Rosie Machaersky

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Chas W Jubb (Address) 3135 Wilkins Ave

15 Filed APR 3 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 9 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb 7, 1929, to Apr 9, 1929, that I last saw her alive on April 4, 1929, and that death occurred, on the date stated above, at 9 50 A m.

The CAUSE OF DEATH* was as follows:

Rheumatic Fever

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Mitral insufficiency

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? 3135 Wilkins Ave

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Robert H McGaw M. D.

, 19 (Address) Women's Hospt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Hill Cem DATE OF BURIAL April 12, 1929

20 UNDERTAKER John Ulhut ADDRESS 2008 Orleans

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

44945

CERTIFICATE OF DEATH.

E 44945

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4304 St. Paul ST. 27-49 WARD)

2-FULL NAME. Elisha Clifton Tower

(a) RESIDENCE NO. Troy N.Y. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Carrie Whitcomb Tower

6 DATE OF BIRTH (month, day, and year) Aug 21-1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	1	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pittsfield, Mass

PARENTS

10 NAME OF FATHER E. C. Tower

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Elzina Stebbins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mr. Geo W. Stieff

(Address) 4304 St Paul St

15 FILED MAY 1 0 1929 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9, 1929

17

I HEREBY CERTIFY, That I attended deceased from March 23, 1929, to April 9, 1929.

that I last saw h alive on April 9, 1929,

and that death occurred, on the date stated above, at 9.45 P. m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

Myocarditis, Endocarditis

(duration) yrs. , mos ds.

CONTRIBUTORY (Secondary) arterio-sclerosis

(duration) 20 yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? New York

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) Ronald C. Abercrombie, M. D.

4/9, 1929 (Address) 18 W. Franklin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Troy N.Y. DATE OF BURIAL April 10 1929

20 UNDERTAKER Wm J Pickerell Sons ADDRESS Mount Pa

Spec.—1-10-21—M&T—1500 Bks.

E 44946

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 44946

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Women's Hospital

CITY OF BALTIMORE: (No.) 1 ST., 13-20 (WARD)

2-FULL NAME Agnes Sullivan

(a) RESIDENCE NO. 746 Lennox ST., 32 WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (Write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug. 20, 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	7	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Daniel R. Sullivan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Eleanora McNeil

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Katharine Kirby (Address) 746 Lennox Street

15 APR 10 1929 C. HENDERSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9, 1929

17 I HEREBY CERTIFY, That I attended deceased from 11 PM April 8, 1929, to 12:30 AM April 9, 1929, that I last saw h[illegible] alive on April 9, 1929, and that death occurred, on the date stated above, at 12:30 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. Hour

CONTRIBUTORY (Secondary) Hypertension

(duration) yrs. mos. ds.

Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What was confirmed diagnosis?

(Signed) Francis A. Langley, M. D.

, 19 (Address) Women's Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	4/12, 1929

20 UNDERTAKER Henry U. Mears & Sons ADDRESS 8 N. Calvert

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

44947

CERTIFICATE OF DEATH.

117 E 44947

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Balto. Gen. Hosp. (WARD)

2-FULL NAME Maurice Kreida

(a) RESIDENCE No. 1121 S Caey ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 9-1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or... min.
	9	7	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Geo. H. Kreida

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Miss Gross

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Hospital Records

(Address)

15 Registered Oct 13 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1929

17 I HEREBY CERTIFY, That I attended deceased from March 29, 1929, to April 10, 1929, that I last saw him alive on April 10, 1929, and that death occurred, on the date stated above, at 9.40 a.m.

The CAUSE OF DEATH* was as follows:

Ruptured Appendix

Intestinal Obstruction

(duration) yrs. mos 12 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of March 29-1929

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Operative

(Signed) Benj. Sarubin, M. D.

4/10, 1929 (Address) West Balto. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem DATE OF BURIAL 4/10 1929

20 UNDERTAKER Jack Lewis ADDRESS 1439 E Balto

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44948 92 **E 44948**

CERTIFICATE OF DEATH

1-PLACE OF DEATH — REGISTERED NO.

City of BALTIMORE: (No. Mercy Hospital St., 5-6 Ward) or

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Deckelman (Deckerman)

(a) RESIDENCE NO. 112 N. Arguith St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S. If of foreign birth 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mollie Deckelman

6 DATE OF BIRTH (month, day, and year) Abt 1880

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watch maker

(b) General nature of industry, business, or establishment in which employed (or employer) 39

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Russia

PARENTS

10 NAME OF FATHER Jacob Deckelman

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Lena

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Wm. A. Deckelman

(Address) Madison & Wilson Sts

15 Filed ... C. HARRISON JONES, Registrar

Per ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/10/29 19

17 I HEREBY CERTIFY, That I attended deceased from 4/8/29 19 .. to 4/10/29 19 ..,

that I last saw h.. alive on 4/10/29 19 ..,

and that death occurred, on the date stated above, at 6-40 A.M. m.

The CAUSE OF DEATH* was as follows:

1a Chronic Cystitis

(duration) 35 yrs. mos. ds.

CONTRIBUTORY (Secondary) Coronary Thrombosis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? (, , .

What test confirmed diagnosis? Clinical

(Signed) F. S. Winstead, M. D.

4/10. 1929 (Address) Mercy Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balt Hebrew Cem — Date of Burial 4/11 1929

20 UNDERTAKER Jack Lewis — ADDRESS 1439 E Baltimore

very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 3ks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44949 | CERTIFICATE OF DEATH | E 44949

1802

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hosp. St 17-24 Ward)

2-FULL NAME Hensen Dorsey

(a) RESIDENCE NO. 625 W Lanvale St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. 3 mos. 6 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fannie Dorsey,

6 DATE OF BIRTH (month, day, and year) Jan 1-1867

7 AGE	Years	Months	Days	IF LESS than 1 day.... hrs. or .... min.
	62	3	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Butler
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER Unk

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country)

12 MAIDEN NAME OF MOTHER .....

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

14 Informant Fannie Dorsey
(Address) 625 W Lanvale

15 Filed ....., 19.. C. HAMPSON JONES, M. D., Registrar
101929 Per .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) April 7 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Obstruction

..... (duration) ..... yrs. 1 day mos.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. Leslie Knight, M. D.
April 7th 29 (Address) Coroner

*(State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lane Cemetery	4/11 1929

20 UNDERTAKER Mrs. Eliz. A. Holland ADDRESS 1613 Druid Hill

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 44950

REGISTERED NO. E 44950

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3629 Chestnut Ave (WARD)

2—FULL NAME Margaret Marsh

(a) RESIDENCE NO. 3629 Chestnut Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of: Samuel Marsh

6 DATE OF BIRTH (month, day, and year): April 4 | 71

7 AGE: Years 58 | Months | Days 6 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mary A Griffith

(Address): 3629 Chestnut Ave

Filed APR 10 1929, 19 C. HAMPSON JONES, Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 10 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1928, to April 10, 1929, that I last saw h alive on April 9, 1929, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Diabetis. mellitus

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical signs

(Signed) C. F Eckhardt M. D.

4/10, 1929 (Address) 370 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Homdel — DATE OF BURIAL: April 12 1929

20 UNDERTAKER: Ehrenwerth & Son — ADDRESS: 1517 Chestnut Ave

Spec.—2-29-28—L. F. S.—500 Bks.

E 44951

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

✓ + 97-802

E 44951

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Md University Hospital ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Marion Emelia Tucker

(a) RESIDENCE NO. Severn, Md ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1921

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	8			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School girl.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore.
(State or country)

PARENTS

10 NAME OF FATHER Wm McKinley Tucker.

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Helen E. Eder.

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country)

14 Informant Wm McKinley Tucker.
(Address)

15 01929 THAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/8/29

17

I HEREBY CERTIFY, That I attended deceased from 4/4/, 1929, to 4/8/, 1929, that I last saw h[illegible] alive on 4/8/, 1929, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Cerebrovo Lesion
Thrombosis.

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Tumor in cerebrum. (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. T. Tumbusch, M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Marys Hempstead

DATE OF BURIAL Apl 11, 1929

20 UNDERTAKER Ebenezer Lee Chestnut

ADDRESS 817

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44952

CERTIFICATE OF DEATH

Wooden

91-00

E 44952

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 920 East Preston ST., 9-18 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Josephine L. Newcomb

(a) RESIDENCE NO. 920 East Preston ST., WARD 9th

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6a If married, widowed, or divorced (or) WIFE of Robert A. Newcomb

6 DATE OF BIRTH (month, day, and year) Jan 5-1859

7 AGE: Years 70 | Months 3 | Days 4 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

10 NAME OF FATHER Thomas Wells

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Anna Styles

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Louis Klug

(Address) 920 E. Preston

15 Filed [illegible], 19 HAMPSON JONES, M. D. Registrar

191925

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9-29

17 I HEREBY CERTIFY, That I attended deceased from March 7th, 1929, to April 9th, 1929, that I last saw h[illegible] alive on April 8th, 1929, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Hypertension

(duration) 2 yrs. mos. 30 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 2 yrs. mos. 30 ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Howard C. Woodrow, M. D.

4/9, 1929 (Address) 5306 E. North avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: 4/12 1929

20 UNDERTAKER: Wm. Cook — ADDRESS: 1217 St Paul

Spec.—1-12-23—M&T—500 Bks.

E 44953

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

51 ✓ × E 44953

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West Balto Gen'l Hosp ST. 16-68 WARD)

2-FULL NAME George Chase

(a) RESIDENCE NO. Toneytown Md ST. WARD

(Usual place of abode)

Length of residence in city or town where death occ. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Johnson

6 DATE OF BIRTH (month, day, and year) Nov 13, 1861

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min
64	4	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md

PARENTS

10 NAME OF FATHER George P. Chase

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Mary A. Mason

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Geo. P. Chase

(Address) Taneytown Comm

Dec. 14, 1929 HAMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1929

17 I HEREBY CERTIFY, That I attended deceased from 3-16-29, 19 ... to April 10, 19 29

that I last saw him alive on April 10, 19 29

and that death occurred, on the date stated above, at 2.35 A. m.

The CAUSE OF DEATH* was as follows:

Burger's disease

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) hypostatic pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jack J. Singo, M. D.

19 (Address) West Balto Gen'l Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount

DATE OF BURIAL April 11 19 29

20 UNDERTAKER J. H. Cook

ADDRESS 214 Park Ave

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44954

CERTIFICATE OF DEATH.

3/ E 44954

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 253 S Caroline St. 3-4 Ward)

2-FULL NAME Anthony Germano

(a) RESIDENCE NO. 253 S. Caroline St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of now

6 DATE OF BIRTH (month, day, and year) Dec 6 1911

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	17	4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of indnstry, business, or establishment in which employed (or employer) Journeyman

(c) Name of employer Lawrence

9 BIRTHPLACE (city or town) Albany N. Y.

(State or country)

PARENTS

10 NAME OF FATHER Carmel Germano

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Italy

12 MAIDEN NAME OF MOTHER Peregina Marina

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Italy

14 Informant Salvator Germano

(Address) 253 S Caroline

C. HAMPSON JONES, M. D.

Registrar

01929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) 1 mos. ds.

(Signed) James M Benton M. D.

(Coroner)

4-9-1929 (Address) 700 Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Date of Burial April 1927

20 UNDERTAKER Wendell & Heppe ADDRESS 202 S Eden

Very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

Grant

E 44955 HEALTH DEPARTMENT—CITY OF BALTIMORE 46 E 44955

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 11-76

CITY OF BALTIMORE: (No. 608 N Fremont Ave WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Adele Wilson Grant

(a) RESIDENCE NO. 608 N Fremont Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE

5 Single, Married, Widowed, or Divorced, (write the word) Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Grant.

6 DATE OF BIRTH (month, day, and year) March 1894

7 AGE Years 35 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Charles Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Josephine Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Arthur Wilson

(Address) 608 N Fremont Ave

15 Date received 4-10 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9 1929

17 I HEREBY CERTIFY, That I attended deceased from March 20, 1929, to April 9, 1929

that I last saw h[illegible] alive on April 9, 1929

and that death occurred, on the date stated above, at 2:15 m.

The CAUSE OF DEATH* was as follows:

Carcinomatosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No Physician

What test confirmed diagnosis?

(Signed) [illegible], M. D.

4-10 1929 (Address) 508 James St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
mt Olivet Cemetery	April 12 1929

20 UNDERTAKER Eugene Waters ADDRESS 615 Caroline St

Spec.—2-29-28—L. F. S.—500 Bks.

E 44956 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

38 E 44956

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 217 n Carrollton Ave (Street) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ida Holland

(a) RESIDENCE NO. 217 n Carrollton Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	M

a If married, widowed, or divorced HUSBAND of (or) WIFE of James Holland

6 DATE OF BIRTH (month, day, and year) Dec 20 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	3	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER unk

11 BIRTHPLACE OF FATHER (city or town) (State or country) unk

12 MAIDEN NAME OF MOTHER unk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unk

14 Informant James Howard

(Address) 217 n Carrollton Ave

Filed APR 11 1929 HAMPSON JONES, M. D.

Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 8, 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 25, 1929, to April 8, 1929.

that I last saw h[illegible] alive on April 8 1929

and that death occurred, on the date stated above, at 9 06p m.

The CAUSE OF DEATH* was as follows:

Cirrhosis Liver

(duration) yrs. 2 mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Jos E Holland, M. D.

April 8 1929 (Address) 508 [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Cemetery

DATE OF BURIAL April 11 1929

20 UNDERTAKER Mrs Katie R. Williams

ADDRESS 322 N Schroeder St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44957

CERTIFICATE OF DEATH

E 44957
REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
City of Baltimore: (No. 219 N Schroeder St. 18-26 Ward)

2-FULL NAME Patty Freeland

(a) RESIDENCE NO. 219 N Schroeder St., Ward
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	Colored	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	IF LESS (than 1 day ..... hrs. or ..... min.
	1		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER Alfred Freeland

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary Edwards

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Sarah Ruffin
(Address) 119 N. Schroeder St

Filed ..... 1929 H. HANSON JONES, M. D., Registrar
By .....

R11929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 8 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Cap Bronchites
Edema (duration) 2 yrs. mos. 7 ds.
CONTRIBUTORY (Secondary) Pneumonia
(duration) yrs. mos. ds.

38 Where was disease contracted if not at place of death? —
Did an operation precede death? — Date of —
Was there an autopsy? —
What test confirmed diagnosis? —

(Signed) H. C. Eades, M. D.
19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	April 11 1929

20 UNDERTAKER Mrs Hattie R Hellems
ADDRESS 322 N Schroeder St

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

224110

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44958

CERTIFICATE OF DEATH

118-002

E 44958

1—PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

CITY OF BALTIMORE: (No. 27-54 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Columbus Rogers

(a) RESIDENCE NO. 1814 Ridgely Road ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	black	married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary

6 DATE OF BIRTH (month, day, and year) 4-10-87

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER James Rogers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Young

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 APR 11 1929 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10-1929

17 I HEREBY CERTIFY, That I attended deceased from April 6, 19 29, to April 10, 19 29, that I last saw him alive on April 10, 19 29, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of April 7, 1929

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Harvey Gardner M. D.

, 19 (Address) Johns Hopkins Hospital Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	4-11 1929

20 UNDERTAKER Daniel Easton Co

ADDRESS 916

Spec.—1-10-21—M&T—1500 Bks.

Erb

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44959

CERTIFICATE OF DEATH.

84

E 44959
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Aisquith Street 901 ST., 10-14 WARD)

2-FULL NAME M. Fonseca Erb

(a) RESIDENCE No. Sisters of Notre Dame Aisquith ST., 901 WARD
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 18/1872

7 AGE 56 Years 11 Months 10 Days 22 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Religious

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Rochester N. Y.
(State or country)

PARENTS

10 NAME OF FATHER John Erb

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Hessen Germany

12 MAIDEN NAME OF MOTHER Elizabeth Schaefer

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Sisters of Notre Dame
(Address)

15 Filed 111529 C. H. JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1929

17 I HEREBY CERTIFY, That I attended deceased from August, 1927, to April 10, 1929, that I last saw her alive on April 10, 1929, and that death occurred, on the date stated above, at 1.30 P. m. m.

The CAUSE OF DEATH* was as follows:

Cancer of Breast
Peritoneal Sepsis

(duration) 12 yrs. mos ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) J. J. Kirby, M. D.

4/10, 1929 (Address) 1105 Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Notch Cliff | DATE OF BURIAL April 12 1929

20 UNDERTAKER Frank A. Fink | ADDRESS 9151 Gay St

Important: Entry must be made in every case. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 44960

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44960

CERTIFICATE OF DEATH

90

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS [redacted] REGISTERED NO.

CITY OF BALTIMORE: (No. [redacted] ST. 25-33 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alonzo Simms

(a) RESIDENCE NO. 24 Ridgely St., Mt. Winans. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm. Simms

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Louisa Brooks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Records of

(Address) BALTIMORE CITY HOSPITALS

15 [redacted]

PR 111929 HANSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 7, 1929

17

I HEREBY CERTIFY, That I attended deceased from March 22, 1929 to April 7, 1929

that I last saw him alive on April 7, 1929

and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic, c

insufficiency & Cyphoscoliosis

(duration) over yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis & Hypertension

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Typical Exam

(Signed) Marvin M. Mc Kean M. D.

, 19 BALTIMORE CITY HOSPITALS (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn cy	April 11 1929
20 UNDERTAKER	ADDRESS
D. Leonard Wheeler	649 Pierce St

Spec.—2-29-28—L. F. S.—500 Bks.

Queens

E 44961

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 129

E 44961

REGISTERED NO.

1—PLACE OF DEATH 8 South Penpont Street

CITY OF BALTIMORE: (No. 8 South Penpon ST. 72-28 (AVE.)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Samuel Earl Owens

(a) RESIDENCE NO. Annapolis Md ST., 3 WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Lizette Lucien Owens

6 DATE OF BIRTH (month, day, and year) September 8 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40	7	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barkeeper

(b) General nature of industry, business, or establishment in which employed (or employer) Naval Academy

(c) Name of employer Naval Academy

9 BIRTHPLACE (city or town) Annapolis Md
(State or country)

PARENTS

10 NAME OF FATHER Samuel P. Owens

11 BIRTHPLACE OF FATHER (city or town) A. A. County Md
(State or country)

12 MAIDEN NAME OF MOTHER Elma A. Basil

13 BIRTHPLACE OF MOTHER (city or town) Annapolis Md
(State or country)

14 Informant Mrs. Earl Owens

(Address) 8 South Penpont Street

15 Filed 1929 C. HAMPSON JONES, M. D.

Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11th 1929

17 I HEREBY CERTIFY, That I attended deceased from March 18, 1929, to April 11, 1929, that I last saw him alive on April 11, 1929 and that death occurred, on the date stated above, at 5:30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Anaemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Annapolis Md

Did an operation precede death? No Date of

Was there an autopsy? —

What test confirmed diagnosis? Dr. Pincoffs Baltimore

(Signed) A. H. A Mayer, M. D.

IV. 11, 1929 (Address) 2438 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Annapolis Md — DATE OF BURIAL April 11 1929

20 UNDERTAKER Jas S. Taylor Sons — ADDRESS Annapolis Md.

Spec.—2-29-28—L. F. S.—500 Bks.

E 44962

HEALTH DEPARTMENT—CITY OF BALTIMORE

86-092

E 44962

CERTIFICATE OF DEATH

1—PLACE OF DEATH Union Memorial Hospital. REGISTERED NO. 12-49

CITY OF BALTIMORE: (No. 33rd. ST. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William J Bissell. Jr

(a) RESIDENCE NO. 3547 Newland Rd ST., Guilford WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. 9 mos. 25 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 16, 1917

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	11	9	25 24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student,

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER William J. Bissell

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Clara Lettig.

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md.

14 Informant Hospital Records.

(Address)

15 1929 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 1st., 1929, to April 10, 1929, that I last saw him alive on April 10, 1929, and that death occurred, on the date stated above, at 4 10 P. m.

The CAUSE OF DEATH* was as follows:

Mastoiditis 6 wks.

Brain abscess 4 wks.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Meningitis (Hemolytic Streptococcus)

(duration) 0 yrs. 0 mos. 4 ds.

18 Where was disease contracted if not at place of death? 3547 Newland Road.

Did an operation precede death? Yes. (2) Date of 7/1/24, 4/4/29

Was there an autopsy? No

What test confirmed diagnosis? Culture and Lumbar Puncture.

(Signed) I C Thompson, M. D.

4/10, 1929 (Address) Union Memorial Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	April 12 1929
20 UNDERTAKER	ADDRESS
Harry Jenkins Son Co	Highland & Mt. Holly Sts

Spec.—2-29-28—L. F. S.—500 Bks.

Kenneth Lamont

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44963

CERTIFICATE OF DEATH

90

E 44963

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Kenneth Lamont 4 WARD)

2—FULL NAME ~~Kenneth Lamont~~

(a) RESIDENCE NO. 721 S. Broadway ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., If foreign birth? 70 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Mrs. Lamont

6 DATE OF BIRTH (month, day, and year) July 3 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	9	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of Industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) ?
(State or country) N. Y.

PARENTS

10 NAME OF FATHER Alexander Lamont

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) N. Y.

12 MAIDEN NAME OF MOTHER Barbara McVey

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) Scotland

14 Informant Records Office
(Address) BALTIMORE CITY HOSPITALS

15 Filed APR 11 1929 C. HAMPTON JONES M.D. Registrar

R 111929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-8-29

17 I HEREBY CERTIFY, That I attended deceased from 4-4, 1929, to 4-10, 1929, that I last saw h alive on 4-10, 1929 and that death occurred, on the date stated above, at 2 30 A m.

The CAUSE OF DEATH* was as follows:

Thrombosis, Coronary Acute
Myocardial Insufficiency

over

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical exam

(Signed) Marion M. McLean, M. D.

4-10, 1929 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn	April 11 1929
20 UNDERTAKER	ADDRESS
M. W. E. Dupp[illegible] Inc	32[illegible] Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44964

CERTIFICATE OF DEATH

E 44964

REGISTERED NO. 25178

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Baltimore City Hospitals (ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Edward Hopkins

(a) RESIDENCE NO. 3215 Sun st., (ST.) Fairfield, Md. (WARD)

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1910

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	19			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Delaware

PARENTS

10 NAME OF FATHER John Hopkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary Frames

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Delaware

14 Informant Hospital Records

(Address)

15 Filed 1 1929 By C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1929, to April 9, 1929, that I last saw him alive on April 9, 1929 and that death occurred, on the date stated above, at 5.45 a. m.

The CAUSE OF DEATH* was as follows:

Bacterial endocarditis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical and autopsy

(Signed) Henry Smith, M. D.

4-9-, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Calvary Cem	4-12 1929

20 UNDERTAKER Byron & Engle

ADDRESS 1218 N. Mc Calvary St

Cor.—10-10-29—A Co.—100 Bks.

important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44965

CERTIFICATE OF DEATH

X 1-001 ✓

REGISTERED NO. E 44965

1-PLACE OF DEATH

City of Baltimore: (No. Johns Hospital St., 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Martha Tyler

(a) RESIDENCE NO. 121 York Road Mr Towson St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 26/1920

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	8	4	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Towson Md.

PARENTS

10 NAME OF FATHER Geo. H Tyler

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Towson, Md.

12 MAIDEN NAME OF MOTHER Florence Smart

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Towson. Md.

14 Informant Geo. H. Tyler
(Address) 121 YorkTowson, Md.

15 Filed 1 1929 C. HAMPSON JOHNS, M. D. Registrar

R 1 1 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 9/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Typhoid Ulcer in Ilium with perforation & Peritonitis.

Acute Splenic Tumor.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? Yes at Hopkins

What test confirmed diagnosis?

(Signed) [illegible], M. D.

4/11/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pleasant Rest Towson Md	4 11 1929
20 UNDERTAKER	ADDRESS
Byron Keigler	218 McCulloh St

Spec.—1-12-23—M&T—500 Blks.

E 44966

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-61

E 44966

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hosp ST. 5-8 (WARD)

2-FULL NAME Maurice D. Koppelman

(a) RESIDENCE NO. 600 N. Eden ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 32 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 32 yrs. ... mos. ... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ida Koppelman

6 DATE OF BIRTH (month, day, and year): 3-29-1880

7 AGE — Years: 49 — Months: 0 — Days: 13 — If LESS than 1 day, hrs. or ... min.: 2

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Grocery

(b) General nature of industry, business, or establishment in which employed (or employer): Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Herman Koppelman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Helen Spiegel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Dr. M. Koppelman
(Address) 1579 or 15 [illegible]

15 Filed APR 11 1929 HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/11 1929

17 I HEREBY CERTIFY, That I attended deceased from 3/28, 1929, to 4/11, 1929, that I last saw him alive on 4/11, 1929, and that death occurred, on the date stated above, at 3:30 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos 16 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Physical Examination

(Signed) A. L. Silver, M. D.

4/11, 1929 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale — DATE OF BURIAL: 4/11 1929

20 UNDERTAKER: Jack Lewis 1439 E. Baltimore St — ADDRESS

FROM IS very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 44967 HEALTH DEPARTMENT—CITY OF BALTIMORE E 44967

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hospital ST. 15-21 WARD)

2-FULL NAME Mr. Louis Rosenstock

(a) RESIDENCE NO. 701 Cumberland Ave ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lena Rosenstock

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	57	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Sarah Berkey
(Address) 701 Cumberland Ave

15 Filed 1923 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-10 1929

17

I HEREBY CERTIFY, That I attended deceased from Mar. 1st, 1929, to April 10, 1929, that I last saw him alive on April 10, 1929, and that death occurred, on the date stated above, at 5.30 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) Carcinoma of R Antrum

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

4/10, 1929 (Signed) Samuel W. Hankin, M. D.
(Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Mt Carmel	4/11 1929

20 UNDERTAKER Jack Lewis ADDRESS 1439 E Baltimore St

FOR IS very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 44968

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44968

CERTIFICATE OF DEATH

905

1—PLACE OF DEATH

REGISTERED NO. 15-21

CITY OF BALTIMORE: (No. 1803 N. Monroe St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Abraham Seidel

(a) RESIDENCE NO. 1803 N. Monroe St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Dina Seidel

6 DATE OF BIRTH (month, day, and year): Unk

7 AGE — Years: 65 — Months: — — Days: — — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Grocer

(b) General nature of industry, business, or establishment in which employed (or employer): Own

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: David Seidel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Roal

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Jack Lewis

(Address): 1439 E. Baltimore

15 Filed 19 HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 11, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 7, 1929, to April 11, 1929, that I last saw him alive on April 11, 1929 and that death occurred, on the date stated above, at 1:30 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Cardiac Disease

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. H. Isaacs, M. D.

19 (Address) 1912 W. North ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Northern Circle

DATE OF BURIAL: 4/11 19 29

20 UNDERTAKER: Jack Lewis

ADDRESS: 1439 E. Balto St

Spec.—2-29-28—I. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44969 — CERTIFICATE OF DEATH — E 44969

91-002

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4115 (Street) Kiernan Ave (Ward) 27-41

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary A. Doehring

(a) RESIDENCE NO. 4115 Kiernan Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if foreign birth 46 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: August F. Doehring

6 DATE OF BIRTH (month, day and year): Jan 22/56

7 AGE — Years: 73 — Months: 2 — Days: 16 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 637

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Frederick Flagg

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Caroline —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Marie Lusakowski

(Address) 4113 Kiernan Ave

15 Received APR 11 1929 — HAMILTON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 7/29

17 I HEREBY CERTIFY, That I attended deceased from July 19, 1928, to April 8, 1929, that I last saw h. alive on June 7, 1929 and that death occurred, on the date stated above, at 10 30 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Pulmonary Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J. Lovell, M. D.

4/9, 1929 (Address) 413 N Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Cem — DATE OF BURIAL: Apr 11 1929

20 UNDERTAKER: Philip Herwig — ADDRESS: 2016 Orleans St

Spec.—2-29-28—L. F. S.—500 Bks.

E 44970

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 44970

REGISTERED NO. 185

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3600 Keystone Ave. ST., 13 WARD)

2—FULL NAME Charles M. Hessong

(a) RESIDENCE NO. 3600 Keystone Ave ST., 13 WARD
(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. — mos. — ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 16-1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	11	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Textile Overseer

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 2 years

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER Thomas K. Hessong

11 BIRTHPLACE OF FATHER (city or town) (State or country) Frederick Co. Md.

12 MAIDEN NAME OF MOTHER Margret Mullen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Charles M. Burgee

(Address) 3600 Keystone Ave

Filed APR. 11 1929 WILSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9-1929

17 I HEREBY CERTIFY, That I attended deceased from Mar 19th, 1929, to April 9th, 1929, that I last saw h[illegible] alive on April 8th, 1929 and that death occurred, on the date stated above, at 4.45 P. m.

The CAUSE OF DEATH* was as follows:

Broken left femur,
Shock. Accidental fall from
top of [illegible] to flat roof of [illegible]

(duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary) Senility.

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? [illegible]

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) T. O. Fellrod, M. D.

April 10, 1929 (Address) 36 W. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's (Hampden)	April 11 1929
20 UNDERTAKER Horace M. Burgee	ADDRESS 631 Falls Road

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44971

CERTIFICATE OF DEATH.

90 E 44971

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3105 Fleet St. 1-2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME WILLIAM KREPP

(a) RESIDENCE NO. 3105 Fleet St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Krepp

6 DATE OF BIRTH (month, day, and year) November 1, 1871

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	57	6	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Retired 5 years

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Michael Krepp

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Simmler

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs. Emma Krepp (Wife)

(Address) 3105 Fleet Street

Filed APR 11 1929 S. HAMPSON JONES, M. D. Registrar

By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9, 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

Exhaustion (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Myocarditis (duration) yrs. mos. ds.

(Signed) M. D.

, 19 (Coroner) (Address) 1436 Bpway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel Cemetery — Date of Burial: Apr. 12, 1929

20 UNDERTAKER: Henry Sander & Sons, Inc. — ADDRESS: BALTIMORE ST. & BROADWAY.

IF DEATH IN PAST TENSE, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 44972

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

167-001

E 44972
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1115 W Lanvale St. 16-23 (Ward)

2-FULL NAME Jas H. Lancaster

(a) RESIDENCE NO. 1115 W Lanvale St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lelia Lancaster

6 DATE OF BIRTH (month, day, and year) Mar 10-1871

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	68	1		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) S. C.
(State or country)

PARENTS

10 NAME OF FATHER Wyatt Lancaster

11 BIRTHPLACE OF FATHER (city or town) S. C.
(State or country)

12 MAIDEN NAME OF MOTHER Sarah Hampton

13 BIRTHPLACE OF MOTHER (city or town) S. C.
(State or country)

14 Informant Lelia Lancaster
(Address) 1115 W Lanvale

Filed APR 11 1929 HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Suicide
Gas Asphyxiation
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Regulary

(Signed) April 10th 1929 (Address) F. B. Leick, M. D. Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery.	Apr. 13 1929
20 UNDERTAKER Henry Sander & Sons Inc	ADDRESS Baltimore St & Broadway

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 44973

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 44973

1—PLACE OF DEATH St Joseph Hospital

REGISTERED NO. 90

CITY OF BALTIMORE: (No. Caroline & Eager ST. 7 WARD 60)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Nora Radigan

(a) RESIDENCE NO. 428 Carroll Ave ST. WARD
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F | 4 COLOR OR RACE W | 5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Michael Radigan

6 DATE OF BIRTH (month, day, and year) 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Flemming

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary Radigan

(Address) 428 N Carrollave

15 11 1929 H. HAMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-10-29

17 I HEREBY CERTIFY, That I attended deceased from 4-6-29, 19..., to 4-10-29, 19..., that I last saw h.e alive on 4-10-29, 19..., and that death occurred, on the date stated above, at 19. m.

The CAUSE OF DEATH* was as follows:

Cholecystitis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of none

Was there an autopsy? no

What test confirmed diagnosis? Clinical Course

(Signed) M B Hendrix, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet | DATE OF BURIAL 4-13-1929

20 UNDERTAKER J. F. Moran | ADDRESS 300 E Baltimore

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44974

CERTIFICATE OF DEATH

× 135

E 44974

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hosp. ST. H-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Oliver Thomas.

(a) RESIDENCE NO. Brenkville, Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Black	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Trackman.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Timod Thomas.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Adeline Dublin.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Patient

(Address)

FILED 11 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/10/29.

17 I HEREBY CERTIFY, That I attended deceased from 4/3/, 1929, to 4/10/, 1929

that I last saw h.. alive on 4/10/, 1929

and that death occurred, on the date stated above, at 5:20 P m.

The CAUSE OF DEATH* was as follows:

Uraemia following Supra-Pubic Cystotomy.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Benign Prostatic Hypertrophy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 4/8/29,

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) E. T. Lambach, M. D.

, 19 (Address) University Hospital,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hyattsville Md	4/11 1929

20 UNDERTAKER Francis Basil Sons

ADDRESS Hyattsville Md

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44975

CERTIFICATE OF DEATH

E 44975

1-PLACE OF DEATH Jenkins Memorial Hospital

City of BALTIMORE: (No. 1009 Calvert Ave. St. 19-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Elizabeth G. Bartlett

(a) RESIDENCE NO. 1714 W. Fayette St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE Years: 74 Months: Days: IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Kent Co.

(State or country) Maryland

PARENTS

10 NAME OF FATHER John M. Bartlett

11 BIRTHPLACE OF FATHER (City or town) Baltimore, Md.

(State or country)

12 MAIDEN NAME OF MOTHER Sallie A. Turner

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Penn.

14 Informant Jenkins Memorial Hospital

(Address) 1009 Calvert Avenue

15 Filed [illegible] C. HAMPSON JONES, M. D. Registrar

R 111929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1929

17 I HEREBY CERTIFY, That I attended deceased from March 26, 1929, to April 10, 1929, that I last saw h[illegible] alive on April 5, 1929, and that death occurred, on the date stated above, at 10:15 a. m.

The CAUSE OF DEATH* was as follows:

Cerebro. Sclerosis

Chronic Nephritis Interstitial

Tuberculosis Pulmonary (Left)

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Hemorrhage

(duration) yrs. 10 mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Physical

(Signed) Nicholas Monnelli, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem

Date of Burial 4 12 29

20 UNDERTAKER Norman Lemmon.

ADDRESS 5 [illegible]

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

44976

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

59-003

E 44976

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 4-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Boy Boone

(a) RESIDENCE NO. ~~University Hospital~~ ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	0	0	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) University Hospital

PARENTS

10 NAME OF FATHER Charles A. Boone

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Thelma Pierpont

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant

(Address)

15 Filed UNIVERSITY OF MARYLAND

THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10th, 1929

17

I HEREBY CERTIFY, That I attended deceased from March 25th, 1929, to April 10th, 1929, that I last saw him alive on April 10th, 1929 and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Malnutrition

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Congenital anus

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of March 28th, 1929

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Lewis B. Tuncliffe, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

APR 11 1929

Cor.—10-10-29—A Co.—100 Bks.

E 44977

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1929 E 44977

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hosp 23-31 St., Ward)

2-FULL NAME Wm Baker.

(a) RESIDENCE NO. 123 Winter St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Baker

6 DATE OF BIRTH (month, day and year): 1886

7 AGE: Years 43; Months; Days; IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town): Va
(State or country)

PARENTS

10 NAME OF FATHER: Baker

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Virginia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Virginia

14 Informant: Mary Baker
(Address): 123 Winter St.

Filed ..... 1929 C. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): April 7th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy & Inquest (inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy & Inquest (inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

(Homicide)

Fractured Skull

(duration) ..... yrs. ..... mos. one ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) H. Leland Taylor M. D.

April 9th 1929 (Address) Coroner.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem

DATE OF BURIAL: 4/10 1929

20 UNDERTAKER: Samuel D. Hemsley

ADDRESS: 518 E. Baltimore St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 44978

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44978

CERTIFICATE OF DEATH

REGISTERED NO. 129

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 513 E. Clement St. (WARD) 24-33

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie Mc Nally

(a) RESIDENCE NO. 513 E. Clement ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Widowed

a if married, widowed, or divorced HUSBAND of (or) WIFE of: Edward Mc Nally

6 DATE OF BIRTH (month, day, and year): June 6 1859

7 AGE — Years: 69 | Months: 10 | Days: 3 | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: John Coghan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: John J. Mc Nally

(Address) 513 E. Clement St.

15 Filed 4-20 19 29 Per HAMPSON JONES, M.D. Registrar.

11529

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 9, 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 1929, to April 9 1929, that I last saw h alive on April 9 1929 and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis with Hypertension

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial nephritis (duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) Sidney H. Street M. D.

4/11 1929 (Address) 445 E. First Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: April 12 1929

20 UNDERTAKER: Margaret E. Flynn — ADDRESS: 14 W. Eight St.

Spec.—2-29-28—L. F. S.—500 Bks.

E 44979

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

40 E 44979

1—PLACE OF DEATH

REGISTERED NO. 24-21

CITY OF BALTIMORE: (No. 1333 Hanover ST. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph F. Russell

(a) RESIDENCE NO. 1333 Hanover St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6 DATE OF BIRTH (month, day, and year): July 4, 1870

7 AGE — Years: 58 Months: 8 Days: 29 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Michael Russell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Ratford

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs George Krauss

(Address) 1333 Hanover St

15 FILED 4-11-29 Registrar: C. HAMPSON JONES, M. D.

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/9/29

17 I HEREBY CERTIFY, That I attended deceased from 4-1, 19 29 to 4-9, 19 29

that I last saw h alive on 4-9, 19 29

and that death occurred on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Acute Pancreatitis

Mitral Insufficiency

Arterial Sclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Terminal Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted, if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Finding

(Signed) Fred Faircloth M. D.

4-11-29 (Address) 800 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: April 1 19 29

UNDERTAKER: Margaret D. Flynn

ADDRESS: 1422 Light St.

Spec.—2-29-28—L. F. S.—500 Bks.

12E 44980

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 44980

1—PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Leonard Ramsay

(a) RESIDENCE NO. Parkside ST., Md —WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Black	

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1925

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md —

PARENTS

10 NAME OF FATHER Luther Ramsay

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Rebecca Carter

13 BIRTHPLACE OF MOTHER (city or town) Md —
(State or country)

14 Informant Reads —
(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... HAMPSON JONES, M.D.
Registrar

R 11929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10-29

17 I HEREBY CERTIFY, That I attended deceased from Feb 6 ..... 1929 ..... to April 10 ..... 1929 ..... that I last saw him alive on April 10 ..... 1929 ..... and that death occurred, on the date stated above, at 3 P- m.

The CAUSE OF DEATH* was as follows:

~~Encephalitis~~ secondary to ~~Meningo~~ Brain Tumor

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) F. C. Goodwin, M. D.

4/11 1929 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Md — DATE OF BURIAL April 11 1929

20 UNDERTAKER J. A. Brogue & Son for John E. Tyrie — ADDRESS 108 W. Monument Baltimore Md

Cor.—12-9-25—A Co.—200 Bks.

E 44981

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44981

CERTIFICATE OF DEATH.

1888

1-PLACE OF DEATH

City of BALTIMORE: (No.) 711 Forest St. 1915 (Ward)

REGISTERED NO.

2-FULL NAME Sam ~~Robinson~~ Robinson

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

(a) RESIDENCE NO. 711 Forest St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	31			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Chesapeake Steamship Co

9 BIRTHPLACE (city or town) Va.

(State or country)

PARENTS

10 NAME OF FATHER Ben. R. Robinson

11 BIRTHPLACE OF FATHER (city or town) Va

(State or country)

12 MAIDEN NAME OF MOTHER Sara L. Robinson

13 BIRTHPLACE OF MOTHER (city or town) Va

(State or country)

14 Informant Martha Robinson

(Address)

15 Filed C. HAMPSON JONES, M. D. Registrar

Per R.R.W.

111929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) April 2 6m 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest Autopsy (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia Contributory

(duration) yrs, mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) M. D.

(Coroner)

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

West Point Va April 3 1929

20 UNDERTAKER ADDRESS

Lottie Gross 1405 McElderry

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 44982 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44982

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Johns Hopkins Hospital. 161-21

CITY OF BALTIMORE: (No. 6-10 St., Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Polocki

(a) RESIDENCE No. 25 N. E. Fairmount St., ave., WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 8, 1929

7 AGE Years ..... Months 2 Days 9 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) .....

(State or country) D. C.

PARENTS

10 NAME OF FATHER Paul Polocki

11 BIRTHPLACE OF FATHER (city or town) .....

(State or country) D. C.

12 MAIDEN NAME OF MOTHER Marguerite Walsh

13 BIRTHPLACE OF MOTHER (city or town) .....

(State or country) D. C.

14 Informant .....

(Address) Johns Hopkins Hospital

15 C. HAMPSON JONES, M. D. Registrar.

Ref. ARR

R 111929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1929

17 I HEREBY CERTIFY, That I attended deceased from 4-8, 1929, to 4-10, 1929, that I last saw him alive on 4-10, 1929, and that death occurred, on the date stated above, at 11.35 A.m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Andrew A. Marchetti, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary

DATE OF BURIAL April 11-29

20 UNDERTAKER D. V. Gazenski

ADDRESS 1930 Eastern Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44983

CERTIFICATE OF DEATH

66 E 44983

1—PLACE OF DEATH Peabody Apartments, REGISTERED NO. 3492-50

CITY OF BALTIMORE: (No. S. E. Cor. Calvert & 30th Sts. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John H. Stocksdale

(a) RESIDENCE NO. Calvert & 30th STS. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 31 yrs. 7 mos. 18 ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) Aug. 21, 1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	31	7	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Harry C. Stocksdale

11 BIRTHPLACE OF FATHER (city or town) Carroll Co
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Grace Hitchens

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mrs. Margaret J. Hitchens
(Address) Calvert & 30th Streets

15 Filed C. HAMPSON JONES, M. D.
R 111929 Per ACA Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-10-29

17

I HEREBY CERTIFY, That I attended deceased from Jan. 1929, to 4-10 1929,

that I last saw h'm alive on 4-9 1929

and that death occurred, on the date stated above, at 3.00 A m.

The CAUSE OF DEATH* was as follows:

CHR. ALCOHOLISM

(duration) 5 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? N. Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John H. Jones, M. D.

4/11/1929 (Address) 1129 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL 4/12 1929

20 UNDERTAKER Hensley & Mears

ADDRESS 805 N. Calvert

Spec.—1-12-23—M&T—500 Bks.

Alice Bryson ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44984 — **E 44984**

CERTIFICATE OF DEATH.

24-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST., 10-14 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Bryson

(a) RESIDENCE NO. Preston & Valley ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
Abt	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Gilbert Bryson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Little Sisters of the Poor Preston & Valley

15 111929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 10 April 1929

17 I HEREBY CERTIFY, That I attended deceased from No record, 19 , to , 19 , that I last saw her alive on April 10, 1929, and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. X. Wurm, M. D.

April 11, 1929 (Address) 1133 Valley St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem — DATE OF BURIAL April 13 1929

20 UNDERTAKER Henry Wenkin & Son — ADDRESS 1210 W Fayette

TION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 44985 HEALTH DEPARTMENT—CITY OF BALTIMORE E 44985

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 513 W. Hamburg St. ST. 21-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Grebe.

(a) RESIDENCE NO. 513 W. Hamburg St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 11 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White.	Married.

5a If married, HUSBAND of Katherine Grebe

6 DATE OF BIRTH (month, day, and year) April 20, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	11	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Henry Grebe.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Eva Schmidt.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Katherine Grebe. (wife)

(Address) 513 W. Hamburg St.

15 Filed 111929 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10. 1929

17 I HEREBY CERTIFY, That I attended deceased from February 10, 1929, to April 10, 1929.

that I last saw him alive on April 10, 1929

and that death occurred, on the date stated above, at 7.30 Pm.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

Hemiplegia (duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Organic disease of the Heart (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? -----

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical diagnosis.

(Signed) Otto M. Reinhardt, M. D.

4/11 1929 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL Apl 13 1929

20 UNDERTAKER Mrs. Thos. J. W. Teufel & Son ADDRESS 531 N. Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 44986

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 44986

89

1—PLACE OF DEATH

REGISTERED NO. 15-61

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2105 Elsinor Av. DIST. WARD)

2—FULL NAME William Edgar Jones

(a) RESIDENCE NO. 2105 Elsinor Av. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth 61 yrs. 5 mos. 19 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Frances Boyd Jones

6 DATE OF BIRTH (month, day, and year) October 22/63

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	5	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Commission Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Produce

(c) Name of employer Self

9 BIRTHPLACE (city or town) Somerset Co.
(State or country) Maryland.

PARENTS

10 NAME OF FATHER David H. Jones

11 BIRTHPLACE OF FATHER (city or town) Somerset Co.
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Julia Scott

13 BIRTHPLACE OF MOTHER (city or town) Somerset Co.
(State or country) Maryland

14 Informant Mrs Virginia B Jones (daughter)
(Address) 2105 Elsinor Ave.

15 Filed 11 1929 C. HAMPSON JONES, M. D. Registrar
BY

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10-29

17 I HEREBY CERTIFY, That I attended deceased from April 9, 1929, to April 10, 1929, that I last saw him alive on April 10, 1929 and that death occurred, on the date stated above, at 3 9 m.

The CAUSE OF DEATH* was as follows:

Acquired Tedious. (Typical)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms & Signs

(Signed) Harlan Cole, M. D.

4/10, 1929 (Address) 2202 Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	April 12 1929.
20 UNDERTAKER Stewart & Mowen Co	ADDRESS Balto.

E 44986

Spec.—1-12-23—M&T—500 Blks.

E 44987 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

135 E 44987

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH West Balto Genl Hospital

CITY OF BALTIMORE: (No. 15-66 ST. WARD)

2-FULL NAME Mr. Ellis Rothman

(a) RESIDENCE No. 4023 Dorlympple ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Rothman Lena

6 DATE OF BIRTH (month, day, and year) April 4, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	63	—	— 7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer self.

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Jac Rothman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Miss Rosenberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Mrs L Rothman

(Address)

15 Filed APR 12 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/11/29

17 I HEREBY CERTIFY, That I attended deceased from 3/26, 1929, to 4/11, 1929, that I last saw him alive on 4/10/29, 1929 and that death occurred, on the date stated above, at 4 99. m

The CAUSE OF DEATH* was as follows:

Hypertrophy of Prostate

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) senility and shock

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 4/10/29

Was there an autopsy? no

What test confirmed diagnosis? Operation & Clinical

(Signed) Paul Wheeler, M. D.

4/11, 1929 (Address) West Balto General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale — DATE OF BURIAL 4/12 1929

20 UNDERTAKER Sol Silverson & Bro — ADDRESS 1127 E Balto st

INSTRUCTION is very important. See instructions on back of certificates. Cause of death in plain terms, so that it may be properly classified. Exact statement of OCCUPA-

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44988
1—PLACE OF DEATH

CERTIFICATE OF DEATH

129 E 44988
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 2326 Jefferson ST., 9-10 WARD)

2—FULL NAME Rosa Peller

(a) RESIDENCE NO. 2326 Jefferson ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept 20-1883

7 AGE — Years: 45 | Months: 6 | Days: 20 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Dressmaker
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS
10 NAME OF FATHER: John A. Peller
11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany
12 MAIDEN NAME OF MOTHER: Mary A. Dorn
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: John H. Peller
(Address): 2326 Jefferson

15 Filed, 19 C. HAMPSON JONES, M. D.
Registrar
Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 9, 29

17 I HEREBY CERTIFY, That I attended deceased from Feb 16, 1929, to April 9, 1929, that I last saw h[illegible] alive on April 9, 1929, and that death occurred, on the date stated above, at 10.40 A m.

The CAUSE OF DEATH* was as follows:
Cerebral Oedema
Endocarditis

CONTRIBUTORY (Secondary) Interstitial Nephritis (duration) yrs. mos. 8 ds.

(duration) 2 yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) F B Saunders, M. D.

, 19 (Address) 719 E. Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem — DATE OF BURIAL: April 13 29

20 UNDERTAKER: Chas C. Miller & Son — ADDRESS: 2334 Jefferson St

Important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44989
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

31 E 44989
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 613 N. Port ST., 7-12 WARD

2-FULL NAME Margaret Schildwachter

(a) RESIDENCE NO. 2327 Milliman ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. 0 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
~~HUSBAND of~~
or) WIFE of Wm. Schildwachter

6 DATE OF BIRTH (month, day, and year) April 4, 1899

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	30	0	4	6.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic 37
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Wm Scherer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Hermia Ruehs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant William Scherer.
(Address) 613 N Port St

15 Filed [illegible] E. HAMPSON JONES, M. D.
Registrar

APR 12 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 11, 1927, to April 10, 1929.
That I last saw h alive on April 9, 1929.
and that death occurred, on the date stated above, at 8 25 A. m.

The CAUSE OF DEATH* was as follows:
Pulmonary tuberculosis,
chronic bronchopneumonia

(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) Bronchopneumonia
(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? unknown
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical & X ray

(Signed) Fred Steerges, M. D.
, 19 (Address) 3034 E Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore County — DATE OF BURIAL: apr. 13 1929

20 UNDERTAKER: Jno E Miller & Son — ADDRESS: 2354 Jefferson St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44990

CERTIFICATE OF DEATH.

92 E 44990

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2914 Church Lane West St. WARD 32

2-FULL NAME Ignatius Urban.

(a) RESIDENCE NO. 2914 Church Lane Westport St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Urban

6 DATE OF BIRTH (month, day, and year) Dec. 12 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	4	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailoring

(b) General nature of industry, business, or establishment in which employed (or employer) Manufact. Coats

(c) Name of employer T. Urban

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER John Uroan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant Geo. Urban

(Address) 2914 Church Lane Westport

15 C. HAMPSON JONES, M. D.

Registrar

R 121929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1929

17

I HEREBY CERTIFY, That I attended deceased from Dec. 1927, to April 10, 1929.

that I last saw him alive on April 10, 1929.

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Auricular Fibrillation

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism

(duration) yrs. mos. 2 minutes

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) A. Brukner M. D.

4/11. 1929 (Address) 37 E. Hamilton St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL 4/13 1929

20 UNDERTAKER Chas. B. Kuchanskas — ADDRESS 637 S. Paca

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

Harris

E 44991

CERTIFICATE OF DEATH. X 45

E 44991

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital ST., 7-13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Abraham A. Harris

(a) RESIDENCE NO. Western Av. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Harry Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Fanny Schiff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1409 E. Balt St

Filed . 19 Registrar

R121929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-11-1929

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1929, to April 11, 1929, that I last saw him alive on April 11, 1929, and that death occurred, on the date stated above, at 2:50 a m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Carcinoma of Sigmoid

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Samuel S. Levin M. D.

4/11, 1929 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Hebrew Cemetery

DATE OF BURIAL 4/13/1929

20 UNDERTAKER Jack Lewis

ADDRESS 1409 E Balt

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44992

CERTIFICATE OF DEATH

74-00 E 44992

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 147 N. MiltonAve St., 6-10 Ward)

2-FULL NAME Anna Engel Barthel

(a) RESIDENCE NO. 147 N. Milton Ave St., 6 Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

Use should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Barthel

6 DATE OF BIRTH (month, day, and year) Sept 29/1874

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	54	6	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md.
(State or country)

PARENTS

10 NAME OF FATHER George Engel

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Mary Dinnick

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto., Md.

14 Informant George Barthel
(Address) 147 N. Milton Ave

15 Filed ..... 19.. THAMPSON JONES, M. D.
Registrar

R 21929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 9/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy-

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Hypertension-Arterio-sclerosis (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Attending Physician

(Signed) J. H. Waring, M. D.

4/11/29 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL April 13 19 29

20 UNDERTAKER Lilly & Feiler Inc

ADDRESS 405 S. Wolfe St

Spec. 2-29-28—L. F. S.—600 Blks.

E 44993

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 44993

1—PLACE OF DEATH

REGISTERED NO. 16-32

CITY OF BALTIMORE: (No. 715 N. Payson St. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Dorothea F. Becker

(a) RESIDENCE NO. 715 N. Payson St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Edward A. Becker

6 DATE OF BIRTH (month, day, and year) Aug. 16, 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	7	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Lutze

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Herman E. Becker

(Address) 1845 W. Pratt St.

15 121329 C. HAMILTON JONES, M. D. /Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1929

17 I HEREBY CERTIFY, That I attended deceased from April 6, 1929, to April 10, 1929, that I last saw h/r alive on April 9, 1929 and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage.

(duration) — yrs. — mos. 4 ds.

CONTRIBUTORY (Secondary) Senile arteris Sclerosis and myocarditis (duration) over 3 yrs yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Henry C. Ohle, M. D.

4-11, 1929 (Address) 203 W. Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	April 12/29
20 UNDERTAKER Harry T. Weitzel	ADDRESS 53 M. Fayette St

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 44994

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001

E 44994

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS [redacted] REGISTERED NO.

CITY OF BALTIMORE: (No. [redacted] ST., 3-E WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Rudolph

(a) RESIDENCE NO. 700 E Bond ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? ? yrs. mos. ds.

important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer ?

9 BIRTHPLACE (city or town) ?
(State or country) Germany

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) Germany

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) Germany

14 Informant Records of
Address BALTIMORE CITY HOSPITALS

15 [redacted]

R 121929 C. HAMPSON JONES M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-9-29

17 I HEREBY CERTIFY, That I attended deceased from 3-28, 19 29, to 7-9, 19 29, that I last saw h[illegible] alive on 7-9, 19 29 and that death occurred, on the date stated above, at 5:15 A m.

The CAUSE OF DEATH* was as follows:

Meningitis Pneumococcus

(duration) yrs. mos. 3 ds. ?

CONTRIBUTORY (Secondary) ? Bronchopneumonia 11 days

Alcoholism (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Lumbar puncture Typical Exam.

(Signed) Marvin M. McLean, M. D.

, 19 BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart

DATE OF BURIAL 7/12 19 29

20 UNDERTAKER John J Fahey Sons

ADDRESS 1318 Light St

Per

Spec.—2-29-28—L. F. S.—500 Bks.

Eliz. P. K. Coolidge

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44995

101-001

CERTIFICATE OF DEATH

E 44995

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 3410 Garrison Blvd (WARD) 15-14

2—FULL NAME Eliza P Coolidge

(a) RESIDENCE NO. 3410 Garrison ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. —mos. —ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	W.	Wid

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 31-1861

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
68		21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Mass
(State or country)

PARENTS

10 NAME OF FATHER Frank Lewis

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Mass

12 MAIDEN NAME OF MOTHER Ellen Stewart

13 BIRTHPLACE OF MOTHER (city or town) Mass.
(State or country)

14 Informant Mr. Robertson, Son in Law

(Address) 3410 Garrison

15 Filed APR 12 1929 HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 11-29

17 I HEREBY CERTIFY, That I attended deceased from Apr 5, 1929, to Apr 11, 1929, that I last saw her alive on Apr 11, 1929, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Acute Myocardial insufficiency with failure. Acct possible secondary pneumonia without obvious physical signs (duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Terminal & Complication of Diseases, (duration) See above yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Consultations

(Signed) Wesley Cole, M. D.

4/11, 1929 (Address) 207 Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Worcester Massachusetts	April 12 1929
UNDERTAKER George E Smith	ADDRESS 1552 Hollins

Be sure the right terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44996

CERTIFICATE OF DEATH.

57 E 44996

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1622 Hollins ST. 14-28 WARD)

2-FULL NAME Annie Virginia VanArsdale

(a) RESIDENCE No. 1622 Hollins ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 25, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	8	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md (State or country)

PARENTS

10 NAME OF FATHER John B Roberts

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md (State or country)

12 MAIDEN NAME OF MOTHER Ann R. Amos

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md (State or country)

14 Informant Thomas S VanArsdale (Address) 1622 Hollins St

15 Filed 4/11 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 10 1929

17 I HEREBY CERTIFY, That I attended deceased from Apr 6, 1929, to Apr 10, 1929, that I last saw her alive on Apr 10, 1929, and that death occurred, on the date stated above, at 9 30 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus,

(duration) 5 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Bronchopneumonia.

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) M Bowman Hood M. D.

4/11, 1929 (Address) 626 N. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	Apr 12 1929
20 UNDERTAKER George J Smith	ADDRESS 153 Hollins

IMPORTANT. Should be Carefully Supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 44997

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-00

E 44997

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City H. 4 ft Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John F. Pickel Jr.

(a) RESIDENCE NO. 23 S. Robinson St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of): Helene J. Schemmig Pickel

6 DATE OF BIRTH (month, day, and year): May 8. 1900

7 AGE: Years 28 Months 11 Days 2 IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Fireman 573

(b) General nature of industry, business, or establishment in which employed (or employer): Pen. R.R.

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER: John F. Pickel Sr.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER: Barbara Baltzer

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore Md.

14 Informant: Wife Mrs. Helene J. Pickel

(Address) 23 S. Robinson St.

C. HANSON GUNLS, M.D.

15 Filed _____ 19 _____

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 10 1929

17 I HEREBY CERTIFY that I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Cerebral R.R. Acc

Multiple Fracture

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (secondary) Stroke

(Duration) ....yrs. ....mos. ....ds.

Apr 11, 29 Witness G. C. Slater M. D.

(Coroner)

19 Address 143 N. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? Corner Ost & Kenwood Pl

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery Date of Burial April 19 1929

20 UNDERTAKER: Emmert W. Conklin ADDRESS 924 E. Eager

AFR 121929

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 44998

CERTIFICATE OF DEATH

E 44998

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 215 N Milton Ave ST., 10 WARD)

2—FULL NAME George W. Smith

(a) RESIDENCE NO. 215 N Milton ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 15 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	48	2	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ice dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Baltimore.

PARENTS

10 NAME OF FATHER George Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Heck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Joe Kelly

(Address) 215 N Milton Ave

15 Filed 12 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10-1929

17 I HEREBY CERTIFY, That I attended deceased from January, 1928, to April 10, 1929, that I last saw him alive on April 9, 1929 and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Inanition and exhaustion due to obstruction in the bowel involving the Sigmoid Ampulla

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cancer of Sigmoid and Ampulla (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Howard L. Silver, M. D.

, 19 (Address) 3706 Liberty Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL

20 UNDERTAKER John Meier

ADDRESS 2000 Ald

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

important. See instructions on back of certificates.

224 E 44999 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1—PLACE OF DEATH JOHNS HOPKINS HOSPITAL REGISTERED NO. E 44999

CITY OF BALTIMORE: (No. ..... ST., 7-9 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Lewis

(a) RESIDENCE NO. Stevensville, Kent Island WARD
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 1 ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
19			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER William Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Rosie Pisard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Parent

(Address) JOHNS HOPKINS HOSPITAL

Filed APR 12 1929 HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11-1929

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1929, to April 11, 1929, that I last saw h alive on April 11, 1929 and that death occurred, on the date stated above, at 7 30 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Rheumatic Endocarditis, Aortic Insufficiency and stenosis. Mitral stenosis and insufficiency. Adhesive mediastinitis & pericarditis, Myocardial Insufficiency

(duration) 3 yrs. 10 mos. ..... ds.

CONTRIBUTORY (Secondary) —

— (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) S. A. Gladstone, M. D.

19 (Address) J. H. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Stevensville Md	4/12/29
20 UNDERTAKER Joseph Ahrens	ADDRESS 221 Bu

Spec.—2-29-28—L. F. S.—500 Bks.

E 45000

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 45000

1—PLACE OF DEATH

REGISTERED NO. 20-64

CITY OF BALTIMORE: (No. 2216 W. Lexington ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Christine Schmidt

(a) RESIDENCE NO. 2216 W. Lexington ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George H. Schmidt

6 DATE OF BIRTH (month, day, and year) August 12, 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	7	30 24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 37

(c) Name of employer At Home

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Frank Hutzky

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mr. George H. Schmidt
(Address) 2216 W. Lexington St.

15 [illegible] C. HAMPSON JONES, M. D.
Registrar

R121523

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1927, to April 11, 1929, that I last saw her alive on April 10, 1929 and that death occurred, on the date stated above, at 11.30 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac dilatation

~~Chronic Valvular Heart Disease~~

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) Chronic valvular heart disease (duration) over 2 yrs. 1 mos. 11 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Test

(Signed) Henry C. Ohle, M. D.

4/11, 1929 (Address) 1203 W. Fayette Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	Apr. 13 1929

20 UNDERTAKER Joseph J Cook

ADDRESS 1003 West Baltimore St

IMPORTANT—Before filling out this certificate, read carefully the instructions on the back. Every question must be answered, as the certificate may be returned for correction if any important item is omitted. Use only black ink. Write plainly. Do not abbreviate. Be sure to give the information required by law. See instructions on back of certificates.

Spec.—8-20-28—L. F. S.—500 Blks.

E 45001 HEALTH DEPARTMENT—CITY OF BALTIMORE E 45001

CERTIFICATE OF DEATH

45

1—PLACE OF DEATH St Joseph Hosp. REGISTERED NO.

CITY OF BALTIMORE; (No. 8-16 ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Caroline Pawuska

(a) RESIDENCE NO. 2103 Sinclair ST. Lane WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Pawuska

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Not Pawuska

(Address) 2103 Sinclair Lane

15 Date 1929 C. HAMPSON JONES, M. D. Registrar

PR121929 Paid

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11/29

17 I HEREBY CERTIFY, That I attended deceased from 4/7/ 1927, to 4/11/29, 19....., that I last saw h.. alive on 4/11/, 1929 and that death occurred the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows:

Malignancy of Sigmoid Colon

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

..... (duration) ..... yrs. ..... mos. 11 days.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 4/10/29

Was there an autopay? no

What test confirmed diagnosis? Clinical

(Signed) J. H. Baumgartner, M. D.

, 19 (Address) St Joseph Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	April 15 1929
20 UNDERTAKER	ADDRESS
Frank Brockhorn	1900 Eastern Ave

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

John Keiner

E 45002 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

124 E 45002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3333 Elmley Ave. (St.) 8-40 (Ward)

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Keiner

(a) RESIDENCE NO. 3333 Elmley Ave. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice Roberts Keiner

6 DATE OF BIRTH (month, day, and year) August 14th. 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min
	38	7	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Garage Manager.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Keiner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Elizabeth Keiner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Alice Roberts Keiner

(Address) 3333 Elmley Ave.

APR 12 1929 C. HAMPSON JONES, M. D. Registrar

By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10th. 1929.

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1929, to April 10, 1929, that I last saw h— alive on April 10, 1929 and that death occurred, on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

Cerebral Hemorrhage (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thos B Lemmon, M. D.

4/11, 1929 (Address) 918 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	4/13, 1929
UNDERTAKER Chas S. Ivans & Son	ADDRESS 1100 N. Royal Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45003

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 45003

REGISTERED NO.

1—PLACE OF DEATH Mt Hope Retreat

CITY OF BALTIMORE: (No. Reisterstown Rd ST. 20-63 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Gertrude C. Trace (Trace)

(a) RESIDENCE NO. Mt Hope Retreat ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. 10 mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Trace

6 DATE OF BIRTH (month, day, and year) Sept 1-1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	7	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wf. of R.R. Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) York. Pa

PARENTS

10 NAME OF FATHER Jno Mayer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Katherine Bolt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) York Pa

14 Informant Jno Robt McGraw

(Address) Pikesville Md.

15 Filed APR 12 1929, 19.. C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/11/29

17 I HEREBY CERTIFY, That I attended deceased from June 3, 1929 to April 11, 1929 that I last saw h.. alive on April 11, 1929 and that death occurred, on the date stated above, at 5 45 P. m.

The CAUSE OF DEATH* was as follows:

Dementia Praecox

(duration) 9 yrs. 10 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis, Pulmonary Oedema (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Freeburg & Hinsey

(Signed) Damian Wilson M.D.

, 19 (Address) 326 Fredericks

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL York Pa — DATE OF BURIAL 4/13 1929

20 UNDERTAKER Chas F. Faust & Son — ADDRESS 118 East Royal ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—1-12-23—M&T—100 Bks.

(Mitchell)

E 45004 HEALTH DEPARTMENT—CITY OF BALTIMORE E 45004

CERTIFICATE OF DEATH.

161-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 204 Ware alley ST., 17-50 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Howard Mitchell

(a) RESIDENCE NO. 204 Ware alley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	C	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER H. Mitchell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Nellie Watkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Nellie Mitchell
(Address) 204 Ware alley

15 Filed 1929 C. HAMPSON JONES, M.D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/10 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia

Bronchial

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) John Thomson, M. D.
(Coroner.)

4/11, 1929 (Address) 3632 Richardson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	APR 1 1929

20 UNDERTAKER	ADDRESS
(Commissioner of Health)	

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

APR 12 1929 3478

Spec.—2-29-28—L. F. S.—500 Bks.

E 45005 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 117 E 45005

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) So Balt Gen Hosp (ST.) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Arthur Uhler

(a) RESIDENCE NO. Westminster St. Md WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Uhler.

6 DATE OF BIRTH (month, day, and year) 1901

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records

(Address)

15 Filed APR 12 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/12/29

17 I HEREBY CERTIFY, That I attended deceased from Apr 4 1929 to Apr 12 1929 that I last saw h[illegible] live on Apr 12 1929 and that death occurred, on the date stated above, at 8 40 a.m.

The CAUSE OF DEATH* was as follows:

Peritonitis

General

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Acute appendicitis

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Westminster Md

Did an operation precede death? Yes Date of 4/5/29

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) Willard N Baker, M. D.

, 19 (Address) So Balt Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westminster Md DATE OF BURIAL 4-15 1929

20 UNDERTAKER H Bankard & Son ADDRESS Westminster

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

PR 12 1929

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45006

CERTIFICATE OF DEATH.

E 45006

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 914 East Lexington ST., 5-8 (WARD)

2-FULL NAME Jane Trimp

(a) RESIDENCE NO. 914 East Lexington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of H. J. Trimp

6 DATE OF BIRTH (month, day, and year) Sept 10, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	72	7	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Thomas Riley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Jane Riley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs A Wagner

(Address) 1083 - East 32 St New York

15 C. HAMPSON JONES, M.D. Registrar

Fee

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11 1929

17 I HEREBY CERTIFY, That I attended deceased from 4/7, 1929, to 4/11, 1929, that I last saw h[illegible] alive on 4/11, 1929, and that death occurred, on the date stated above, at 11:20 A m.

The CAUSE OF DEATH* was as follows:

Ch myocarditis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Ch Nephritis

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) O. G. Hamilton, M. D.

4/12, 1929 (Address) 733 Augusta St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Cathedral

DATE OF BURIAL 4/13 1929

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul

APR 12 1929

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

Dr Fenby 29 E Preston St

E 45007

CERTIFICATE OF DEATH

109

E 45007

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1541 Ensor ST. 9-18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edith Naomi McKinnon

(a) RESIDENCE NO. 1541 Ensor ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 3, 1919

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	9	8	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Duncan McKinnon

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Scotland

12 MAIDEN NAME OF MOTHER Edith Cranbett

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Duncan McKinnon
(Address) 1541 Ensor Street

15 [illegible] 19 C. HAMPSON JONES, M.D.
Registrar

APR 12 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 26, 1929, to April 10, 1929, that I last saw h[illegible] alive on April 10, 1929 and that death occurred, on the date stated above, at 11.30 a. m.

The CAUSE OF DEATH* was as follows:

Acute Hemorrhagic Nephritis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical + Laboratory

(Signed) Dan L. Fenby, M. D.

4/11, 1929 (Address) 29 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	April 13 1929
20 UNDERTAKER	ADDRESS
Wm Cook	1217 St Paul St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45008 E 45008

CERTIFICATE OF DEATH

1—PLACE OF DEATH University Hosp. REGISTERED NO.

CITY OF BALTIMORE: (No. 4-30 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Robert Embrey

(a) RESIDENCE NO. 2 Lansdowne, Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Lillie Embrey

6 DATE OF BIRTH (month, day, and year) Oct 29, 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47.	5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Collins Fork

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Tommie Embrey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Linetta Worley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Linetta Embrey

(Address) 1822 W. Fulton Ave

15 Filed ..., 19 HAMPSON JONES, JR. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12th 1929

17 I HEREBY CERTIFY, That I attended deceased from April 11th, 1929, to April 12th, 1929, that I last saw him alive on April 12th, 1929 and that death occurred, on the date stated above, at 7 A.m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage basilar

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) increased intracranial pressure (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Lansdowne

Did an operation precede death? no Date of

Was there an autopsy? yes. What test confirmed diagnosis? Spinal pund. & autopsy

(Signed) B. G. Warner, M. D.

, 19 (Address) Univ. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn — DATE OF BURIAL 4/15 1929

20 UNDERTAKER J. M. Cook — ADDRESS 217 S. Gilmor

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

APR 12 1929 P.M. AM

Spec.—2-29-28—L. F. S.—500 Bks.

E 45009

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45009

CERTIFICATE OF DEATH

90

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. 9-46 ST., WARD).

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Hattie Furgison

(a) RESIDENCE NO. 3103 Old York Rd. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73 74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Wm. J. Ferguson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Martha ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Records of

(Address) Baltimore City Hospitals

Filed APR 12 1929, 19 CHAMPION JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11, 1929

17 I HEREBY CERTIFY, That I attended deceased from September 28, 19 27 to April 11, 19 29

that I last saw her alive on April 11, 19 29

and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (a)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Marvin W. McLean, M. D.

, 19 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount

DATE OF BURIAL 4 13 1929

20 UNDERTAKER W. M. Cook

ADDRESS 1217 E. Fayette

NOTE—WHILE LEGIBLE, WRITE UNABBREVIATED. THIS IS A PERMANENT RECORD. Every question should be carefully answered. If unknown or not applicable, state so. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45010

CERTIFICATE OF DEATH

90 E 45010

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE (No.) #3523 Chestnut Ave (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A Mc Cullough

(a) RESIDENCE NO. #3523 Chestnut Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 Color or Race White

5 ~~Single, Married,~~ Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Mc Cullough

6 DATE OF BIRTH (month, day, and year) Dec 10 1846

7 AGE Years 79 Months 4 Days 2

IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) — — 37

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) MD

PARENTS

10 NAME OF FATHER Thomas Griffith

11 BIRTHPLACE OF FATHER (City or town) (State or country) MD

12 MAIDEN NAME OF MOTHER Martha Cook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) MD

14 Informant Bertie Sullivan (Address) 3523 Chestnut Ave

15 Filed C. HAMPSON JONES, Registrar

By ATA

MEDICAL CERTIFICATE OF DEATH 4-12-29

16 DATE OF DEATH (month, day, and year) April 12 1929

17 I HEREBY CERTIFY, That I attended deceased from 4-7 1929 to 4-12 1929.

That I last saw her alive on 4-11 1929

And that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Bronchial asthma

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Typical signs

(Signed) C. T. Campbell M. D.

4-12 1929 (Address) 3701 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Congressional MD

Date of Burial April 15 1929

20 UNDERTAKER Eberwein & Son

ADDRESS 361 Cheshire Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

PRINTED REGISTERED FOR BINDING

Spec.—1-10-21—M&T—1500 Blks.

E 45011

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45011

CERTIFICATE OF DEATH.

100-

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 639 W. Conway St., (or) WARD) 21-30

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosabell Smith

(a) RESIDENCE NO. 639 W. Conway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1924

7 AGE: Years 5 (1924) Months 5 Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Bedford Co. Va

PARENTS

10 NAME OF FATHER Samuel Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bedford Co Va

12 MAIDEN NAME OF MOTHER Hattie Royal

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Carol Co Va

14 Informant: Samuel Smith

(Address) 639 W. conway st.

15 C. HAMPSON JONES, M. D. Registrar

By

PR121929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11 1929

17

I HEREBY CERTIFY, That I attended deceased from April 3, 1929, to April 11, 1929,

that I last saw h[illegible] alive on April 10, 1929

and that death occurred, on the date stated above, at 11½ A. m.

The CAUSE OF DEATH* was as follows:

Acute cerebral Meningitis

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

4.12. 1929 (Address) 729 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary Cem.

DATE OF BURIAL 4/13 1929

20 UNDERTAKER [illegible]

ADDRESS [illegible]

P. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 45012 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1022 45012

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1142 N. Linwood St., 6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward E Baker

(a) RESIDENCE NO. 1142 N. Linwood St., 6 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie M. Baker

6 DATE OF BIRTH (month, day, and year) June 1 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	57	9	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Press Feeder

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Crown Cork & Seal Co

9 BIRTHPLACE (city or town) (State or country) Hampden, Md

PARENTS

10 NAME OF FATHER Frederick Baker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hampden Md

12 MAIDEN NAME OF MOTHER Catherine Lott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Annie M. Baker

(Address) 1142 N. Linwood Ave.

15 G. HAMPSON JONES, M. D. Registrar

APR 131929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-11- 1929

17

I HEREBY CERTIFY, That I attended deceased from 4-4-29, 19..., to 4-11, 1929.

that I last saw him alive on 4-11-, 1929

and that death occurred, on the date stated above, at 12 30 p m.

The CAUSE OF DEATH* was as follows:

Pleurisy

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Leo Keller M. D.

4/12, 1929 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Hampden	April 15 29
20 UNDERTAKER	ADDRESS
John F Denny	715 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should WRITE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 45013

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

x 166

E 45013

REGISTERED NO. _____

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) St. Mercy Hospital (St.) (Ward)

2-FULL NAME Helen A Lautenbach

(a) RESIDENCE NO. Phila Pa St. _____ Ward _____

(Usual place of abode) about 2 wks

Length of residence in city or town where death occurred yrs. mos. ds.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced WIFE of (or) HUSBAND of: Howard G Lautenbach

6 DATE OF BIRTH (month, day, and year): Oct 25 1891

7 AGE: Years 37 Months 5 Days 17 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Book Keeper for

(b) General nature of industry, business, or establishment in which employed (or employer): Lumber firm

(c) Name of employer: Fritz at Phila Pa

9 BIRTHPLACE (city or town): Sparrow Point Md

(State or country)

PARENTS

10 NAME OF FATHER: James W Loftus

11 BIRTHPLACE OF FATHER (city or town): Cockeysville Md

(State or country)

12 MAIDEN NAME OF MOTHER: Annie C Hildebrandt

13 BIRTHPLACE OF MOTHER (city or town): Cockeysville Md

(State or country)

14 Informant: Mrs Elizabeth C Loftus

(Address) 516 D St Hebron Pt.

C. THAMPSON JONES, M. D.

Filed _____ 19 _____

Registrar _____

APR 13 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 11 20 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Hydrargyrum

Poisoning by Hydrarg. Bichlor

About 2 wks (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pneumonia

3 days (duration) ..... yrs. ..... mos. ..... ds.

(Signed) M. V. Tracy M. D.

(Coroner)

Apr 12, 192 (Address) 1639 Riverside

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. State about 2 wks in the

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sherwood Enoch Cemetery Cockeysville Md — Date of Burial: April 13 29

20 UNDERTAKER: John F Denny — ADDRESS: 715 Light St

NOTE.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45014 HEALTH DEPARTMENT—CITY OF BALTIMORE E 45014

CERTIFICATE OF DEATH

101-001

1—PLACE OF DEATH Johns Hopkins Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Hannibal Pindell

(a) RESIDENCE NO. 517 N. Somerset ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	B.	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie Pindell

6 DATE OF BIRTH (month, day, and year) Feb. 9-1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Philip Pindell

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant

(Address) Johns Hopkins Hospital

15 Filed ..., 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 11-1929

17 I HEREBY CERTIFY, That I attended deceased from April 9, 1929, to April 11, 1929, that I last saw him alive on April 11, 1929 and that death occurred, on the date stated above, at 4 15 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Sidney A. Gladston, M. D.

, 19 (Address) J. H. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cemetery	Apr. 14 1929
20 UNDERTAKER	ADDRESS
Chas. H. Johnson	416 N. Caroline St.

APR 131929

Marriage should be correctly supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45015

CERTIFICATE OF DEATH

× 90 E 45015

1—PLACE OF DEATH

REGISTERED NO. 12-50

CITY OF BALTIMORE: (No. 2519 N. Charles ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Danton

(a) RESIDENCE NO. 2519 N. Charles ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 8 mos. - ds. How long in U. S., if foreign birth? 60 rs. - mos. - ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

a If married, widowed, or divorced HUSBAND of (or) WIFE of Ferdinand Danton

6 DATE OF BIRTH (month, day, and year) June 28, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	9	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Henry Callaghan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Que

13 BIRTHPLACE OF MOTHER (city or town) (State or country) France

14 Informant Van Eaton Danton

(Address) 2519 N. Charles Street

15 C. HAMPSON JONES, M. D. Registrar

R 131929

Via Penn. Railroad Escort - Dr. Anthony C. Danton

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12/29

17 I HEREBY CERTIFY, That I attended deceased from Feb 28, 1929, to Apr 12, 1929, that I last saw h alive on Apr 11, 1929 and that death occurred, on the date stated above, at 8.30 a m.

The CAUSE OF DEATH* was as follows:

Chr Myocarditis Auricular
Libr. Atrain. Myocardial Insufficiency

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Toxic Adenoma & Thyroid

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not able Stay

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Thyroid exam

(Signed) H. A. W. Longsworth, M. D.

4/13, 1929 (Address) 9E Chas St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem., New York	4/13 1929

20 UNDERTAKER Henry W. Meads & Son ADDRESS 805 N. Calvert

IMPORTANT—Answers to questions must be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill out CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 45016

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45016

CERTIFICATE OF DEATH.

161-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1723 Cairs St. ST. 9-27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Tunstall.

(a) RESIDENCE NO. 1723 Cairs St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 4/10/29

7 AGE — Years — Months — Days: 0

If LESS than 1 day 19 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland.

PARENTS

10 NAME OF FATHER: William Tunstall

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland

12 MAIDEN NAME OF MOTHER: Viola Carr

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant: Wm Tunstall

(Address) 1723 Cairs St

15 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 11 1929

17

I HEREBY CERTIFY, That I attended deceased from April 10, 1929, to April 11, 1929,

that I last saw h[illegible] alive on April 10, 1929,

and that death occurred, on the date stated above, at 10:45 A.m.

The CAUSE OF DEATH* was as follows:

Prematurity.

(34 WEEKS)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Louis A. Mongan M. D.

4/11, 1929 (Address) Municipality Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Auburn DATE OF BURIAL: April 13, 1929

20 UNDERTAKER: Joseph A Lively ADDRESS: 4 W Mount St

P. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PR 131929

Spec.—2-29-28—L. F. S.—500 Bks.

Gunther

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45017 — 1469 — 10 a m

CERTIFICATE OF DEATH

X 90 ~ E 45017

1—PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 16-26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Gunther

(a) RESIDENCE NO. 608 N Caroline ST., WARD Catville Va.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. 19 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	black	married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Maggie

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work laborer odd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N.C.

PARENTS

10 NAME OF FATHER Isaac

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Maggie Rogers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant George (Address) JOHNS HOPKINS HOSPITAL

15 [illegible] 19 C. HAMPSON JONES M.D. Registrar

PR 131929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11-1929

17 I HEREBY CERTIFY, That I attended deceased from April 5 1929 to April 11 1929

that I last saw him alive on April 11 1929

and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Pneumonia Influenza

Hospital Gas Gangrene Streptococcus

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Anemia

(duration) yrs mos. 6 ds.

18 Where was disease contracted if not at place of death? Hospital

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Gas Culture

(Signed) Sidney A. Bradstone, M. D.

4/12, 1929 (Address) 7 Id. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
mount auburn	April 15, 1929

20 UNDERTAKER Joseph A Linly ADDRESS 4042 Mount St

IMPORTANT: Name should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 45018

HEALTH DEPARTMENT—CITY OF BALTIMORE

111-001

E 45018

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Hopkins Hospital St., 10-14 Ward)

2-FULL NAME Henry Moore

(a) RESIDENCE NO. 704 Harford Ave St., Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~~4~~ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	B	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Annie Moore

6 DATE OF BIRTH (month, day, and year) 1889

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	39			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) .....
(State or country) S.C.

PARENTS

10 NAME OF FATHER Mack Moore

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) S.C.

12 MAIDEN NAME OF MOTHER Frances Davis

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) S.C.

14 Informant Annie Moore
(Address) 704 Harford Ave

15 Filed Apr 22 19 29 THOMPSON JONES, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 11/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

General Septic Peritonitis
Due to a probable ruptured gastric ulcer.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? yes Date of just prior

Was there an autopsy? no to death

What test confirmed diagnosis? .....

(Signed) J. F. Weiss, M. D.

4/12/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Edgefield S.C.

DATE OF BURIAL April 14 1929

20 UNDERTAKER Edward Dawson

ADDRESS Lynchburg

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45019

CERTIFICATE OF DEATH

129

E 45019

1—PLACE OF DEATH

REGISTERED NO. .....

CITY OF BALTIMORE: (No. 1419 Orleans ST. 5-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Juila Matthews

(a) RESIDENCE NO. 1419 Orleans ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colord	Widow

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
65	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) V.a

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Juila Campbell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) V.a

14 Informant Mary Ross

(Address) 1419 Orleans St

Filed ..... 19 ..... THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-12-29

17 I HEREBY CERTIFY, That I attended deceased from March 4 1929, to apr 12 1929, that I last saw her alive on apr 12 1929 and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Ch. Nephritis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. A. Hornstein M. D.

4/13 1929 (Address) 733 Aisquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Arbutus Cemetery

DATE OF BURIAL April 13 1929

20 UNDERTAKER Edward Bryson

ADDRESS 1631 Orleans St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PR 131029

Cor.—10-10-29—A Co.—100 Bks.

E 45020

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 45020

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH

City of Baltimore: (No.) 707 Gold St., 15-21 Ward)

REGISTERED NO. 175

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Beatrice Bailey

(a) RESIDENCE NO. 707 Gold. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Fmal	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 16 - 1908

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
20	20	11	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer) Yale Laundry 041
(c) Name of employer

9 BIRTHPLACE (city or town) Balto Co.
(State or country) Md.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) Balto Co
(State or country)

12 MAIDEN NAME OF MOTHER Alphonso Bailey

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Phillip Rogers
(Address) 707 Gold

15 Filed 1929 C. HAMPSON JONES, M. D. Registrar

By

R 131929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Apr 12th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to (his) death on the day stated above.
The CAUSE OF DEATH* was as follows:

Stomach Poison

(duration) yrs.

CONTRIBUTORY (Secondary) Eating spoiled ham

(duration) yrs.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) F. C. Funk, M. D.
Apr 12th 1929 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL 4-13 1929

20 UNDERTAKER Dennis Easton — ADDRESS 916 Eas

Spec.--2-29-28—L. F. S.—500 Bks.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

2236 18 45021

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

117 E 45021

1—PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 1-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Louise Fitzgerald

(a) RESIDENCE NO. 1514 N. Dallas ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W.	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6/18/14

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	14	9	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl.

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Robt Fitzgerald

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Cora Wood

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed C. HAMPSON JONES, M. D. Registrar

APR 13 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 11 1929

17 I HEREBY CERTIFY, That I attended deceased from March 21, 1929, to April 10, 1929, that I last saw her alive on April 10, 1929 and that death occurred, on the date stated above, at 10 05 P. m.

The CAUSE OF DEATH* was as follows:

Acute pneumonitis c perforation
Appendix, resulting generalized
peritonitis & abscess formation + sub
perforation 1 hour (duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia 1+
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home 1514 N Dallas St.

Did an operation precede death? yes Date of Mar 21, 29.

Was there an autopsy? yes

What test confirmed diagnosis? Gross + micr exam

(Signed) Ferdinand C Lee, M. D.

(Apr 11, 1929) (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary

DATE OF BURIAL Apr 14, 1929

20 UNDERTAKER Wm. B. A. Elliott

ADDRESS 1706 Ashland Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45022

CERTIFICATE OF DEATH

129

E 45022

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSPITALS ST. 8-7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edward Smith

(a) RESIDENCE NO. 1314 W Washington ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? — yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) June 4 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	10	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) ? Pa

PARENTS

10 NAME OF FATHER Lawrence? Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) ? Germany

12 MAIDEN NAME OF MOTHER Margaret ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ? Germany

14 Informant (Records) (Address) BALTIMORE CITY HOSPITALS

15 Filed C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-12-29

17 I HEREBY CERTIFY, That I attended deceased from 4-8, 1929, to 4-12, 1929, that I last saw h. alive on 4-12, 1929 and that death occurred, on the date stated above, at 11:20 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis with Uremia

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis chr. Arteriosclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy Clinical Chart

(Signed) Marvel M. [illegible] M. D.

, 19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	April 15 1929
20 UNDERTAKER Henry Lutz	ADDRESS 1203 E Broadway

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

R 131929

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45023

CERTIFICATE OF DEATH

31 E 45023

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2826 W. Lanvale ST. 16-68 WARD)

2—FULL NAME Irma Amelia Lilley

(a) RESIDENCE NO. 2826 W. Lanvale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. 4 mos. 20 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Nov 21, 1907

7 AGE: Years 21 | Months 4 | Days 20 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Office work

(b) General nature of industry, business, or establishment in which employed (or employer): Statistician

(c) Name of employer: Hochschild Kohn & Co

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: James David Lilley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Howard Co Md

12 MAIDEN NAME OF MOTHER: Julia Amelia Wolbrecht

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Mr James D. Lilley

(Address) 2826 W. Lanvale St

15 C. HAMPSON JONES, M.D. Registrar

PR 131929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Sept 10, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 27, 1929 to Sept 10, 1929

that I last saw h. alive on Sept 10, 1929

and that death occurred, on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows: Carcinoma Larynx

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Biopsy and Microscopic

(Signed) Dr C. Hampson Jones, M. D.

9/11, 1929 (Address) 3400 North Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	Sept 13, 1929
20 UNDERTAKER: W. J. Ecker Sons	ADDRESS: North Ave

OF DEATH is plain terms, so that it may be properly classified. Exact statement of OCCUPATION necessary important. See instructions on back of certificates.

Spec.—1-12 23—M&T—500 Blks.

E 45024

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 45024

90

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 4423 Raspr av (St.) 26-42 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elmer Wes Zink

(a) RESIDENCE No. 4423 Raspr av ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ruth Lohefner Zink

6 DATE OF BIRTH (month, day, and year) Jan. 12, 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33	3	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shipping Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Blaser Dresser

9 BIRTHPLACE (city or town) (State or country) Eckeysville Md

PARENTS

10 NAME OF FATHER Conrad Zink

11 BIRTHPLACE OF FATHER (city or town) (State or country) Chesnut Ridge Balto Co. Md

12 MAIDEN NAME OF MOTHER Amanda Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Butler, Balto. Co. Md.

14 Informant Ruth L. Zink

(Address) 4423 Raspr ave

15 Date ..... By C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb - 1929, to April 11, 1929.

that I last saw him alive on April 11, 1929,

and that death occurred, on the date stated above, at 1.45 P m.

The CAUSE OF DEATH* was as follows:

Cardio-Vascular disease

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Typical Pain

(Signed) [illegible], M. D.

, 19 (Address) 836 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL Apr 13 1929

20 UNDERTAKER W. L. Dickinson

ADDRESS Hotel

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PR 13 1929

Spec.—2-29-28—L. F. S.—500 Bks.

Smith

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45025

CERTIFICATE OF DEATH

3 1 E 45025

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION necessary important. See instructions on back of certificates.

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST., 3-4 WARD)

2—FULL NAME Edward F. Smith

(a) RESIDENCE NO. 520 S. Caroline st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1876 Aug 18

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	7	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown 040

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Scotland

PARENTS

10 NAME OF FATHER Dan Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Alice Cullough

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Hospital Records

(Address)

15 C. HAMPSON JONES, M. D.

....., 19 ..... Per ..... Registrar

R 131929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 11, 1929

17

I HEREBY CERTIFY, That I attended deceased from April 4, 1929, to April 11, 1929,

that I last saw him alive on April 11, 1929

and that death occurred, on the date stated above, at 6.55 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical and lab.

(Signed) Geo. C. Smith, M. D.

4-12, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart — DATE OF BURIAL Apr 15 1929

20 UNDERTAKER Philip Herwig — ADDRESS 2016 Orleans St

Spec.—2-29-28—L. F. S.—500 Bks.

E 45026 HEALTH DEPARTMENT—CITY OF BALTIMORE E 45026

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1513 Mosher ST. 16-22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rosa Smith

(a) RESIDENCE NO. 1513 Mosher ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George H. Smith

6 DATE OF BIRTH (month, day, and year): Unknown 1881

7 AGE — Years: 48 | Months: | Days: | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEDENT

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Unk

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Richard Perry

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Edward Holmes

(Address): 513 Mosher

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

Per

R 131929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/17/29

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1929, to April 17, 1929, that I last saw h alive on April 11, 1929, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 3 mos. 9 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) S. A. Hatcher, M. D.

4/18, 1929 (Address) 1515 Druid Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount

DATE OF BURIAL: 4/20 19 29

20 UNDERTAKER: Wm. H. Chesshire

ADDRESS: 450 Mosher

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 45027

E 45027

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Joseph Hospital St. 3-5 Ward)

2-FULL NAME James Elmer Lease

(a) RESIDENCE NO. 910 Fawn St St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 11/29

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
			1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto, Md

PARENTS

10 NAME OF FATHER James Lease

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Mamie Jones

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto., Md.

14 Informant Hannah Cunce
(Address) 910 Fawn St

15 Filed 19 C. HAMPSON JONES, M. D.
Registrar
By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 12/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:
Congenital Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. C. Hamilton M. D.

4/13/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet	April 19 29
20 UNDERTAKER Rudolf Klepper	ADDRESS 1041 W.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

R 131929

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45028

CERTIFICATE OF DEATH

44 E 45028

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1206 E. North Ave. ST., 9-18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John A. Sherman

(a) RESIDENCE NO. 1206 E. North Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Cox

6 DATE OF BIRTH (month, day, and year) May 4, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	11	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Cooperage 0f6

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Sherman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Sara C.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mrs. Margaret Sherman

(Address) 1206 E. North Ave

15 [illegible] THOMPSON [illegible] (Registrar)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 11 '29

17 I HEREBY CERTIFY, That I attended deceased from Dec 27, 1928 to April 11, 1929, that I last saw him alive on April 11/29, 1929 and that death occurred, on the date stated above, at 9:30 p m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Stomach

(duration) yrs. 5 mos. 0 ds.

CONTRIBUTORY (Secondary) Cardiac weakness & Tuberculosis of lung

(duration) yrs. 1 mos. 0 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symps. chemical analysis of gastric contents

(Signed) Julian Friedenwald, M. D.

Apl 13 1929 (Address) 1013 N Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount	Apr. 15, 1929

20 UNDERTAKER Rula Wiedefeld ADDRESS 914 Greenmount Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PR 131929

Spec.—1-12-23—M&T—500 Bks.

E 45029

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45029

CERTIFICATE OF DEATH.

162

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2710 Huron ST. 25-13 WARD)

2-FULL NAME Emma Laurene Schumacher

(a) RESIDENCE NO. 2710 Huron ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 17 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 26/29

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	no	no	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Charles Schumacher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Louise Cottrell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Charles Schumacher (Address) 2710 Huron St

15 Filed Apr 1 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13 1929

17

I HEREBY CERTIFY, That I attended deceased from March 26, 1929, to April 13, 1929, that I last saw h alive on April 13, 1929, and that death occurred, on the date stated above, at 6.30 a m.

The CAUSE OF DEATH* was as follows:

Pneumonia lobar

(duration) 2w yrs. 2w mos 2d ds.

CONTRIBUTORY (Secondary) Umbilical hemorrhage

(duration) no yrs. no mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) [illegible] M. D.

Apr 14, 1929 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL Apr. 13 1929

20 UNDERTAKER George L. Schmidt — ADDRESS 201 Fulton Ave.

mation should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

R 131929

Spec.—2-29-28—L. F. S.—500 Bks.

E 45030

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 45030

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2550 Asquith ST., G-46 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Henry Joerdens

(a) RESIDENCE NO. 2550 Asquith ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. 10 mos. 14 ds. How long in U. S., if foreign birth 30 yrs. 10 mos. 14 ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Goldie Becker Joerdens

6 DATE OF BIRTH (month, day, and year) May 29 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	30	10	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Undertaker.

(b) General nature of industry, business, or establishment in which employed (or employer) Undertaking

(c) Name of employer Jos. Joerdens & Son

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER George Joerdens

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Louisa M. Pelzing

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Maryland.

14 Informant Geo. Joerdens - (father)
(Address) 217 S Paca St

15 Filed ..... 19 C. HAMPSON JONES, M. D. Registrar

PR 131929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12 1929

17 I HEREBY CERTIFY, That I attended deceased from 3/21 1929 to 4/12 1929 that I last saw h[illegible] alive on 4/12 1929 and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis
(Terminal Hemmorhages)

(duration) — yrs. 4 mos. — ds.

CONTRIBUTORY (Secondary) Streptococcus septicaemia

(duration) — yrs. 4 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no What test confirmed diagnosis? Culture taken - Blood &

(Signed) David Brandeau M. D.

4/13. 1929 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	April 15 1929.
20 UNDERTAKER	ADDRESS
Jos Joerdens & Son	217 S Paca

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 45031 X 117 E 45031

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. St. Josephs Hospital 4-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Cassimer Emala

(a) RESIDENCE NO. Bengies, Md ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 22, 1912

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	17	2	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mill Worker

(b) General nature of industry, business, or establishment in which employed (or employer) Hop Mill

(c) Name of employer Eastern Rolling mill

9 BIRTHPLACE (city or town) (State or country) Bengies Md.

PARENTS

10 NAME OF FATHER Frank Emala

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Bienowska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Stephen J. Emala

(Address) Bengies Md.

15 Filed APR 14 1929, 19.. H. LAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-13-29

17 I HEREBY CERTIFY, That I attended deceased from 4-7-29, 19.., to 4-13-29, 19..,

that I last saw h.. alive on 4-13-29, 19..

and that death occurred, on the date stated above, at 10:55 A.m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 4-7-29

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

4/13, 1929 (Address) St. Josephs Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem. DATE OF BURIAL 4/16/1929

20 UNDERTAKER John G. Connelly ADDRESS Essex

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45032

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 44 E 45032

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City/Co ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jake Krencicka (KRINSICKA)

(a) RESIDENCE NO. 690 Fremont Ave ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marion Krinsicka

6 DATE OF BIRTH (month, day, and year) 10/23/1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	5	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) O'Do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) " "

12 MAIDEN NAME OF MOTHER " "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " "

14 Informant Mrs. Grunka

(Address) Eastern Ave

15 Filed APR 14 1929 19 H. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/12/29

17 I HEREBY CERTIFY, That I attended deceased from 3/15, 1929, to 4/12, 1929, that I last saw h alive on 4/11, 1929 and that death occurred, on the date stated above, at 7A m.

The CAUSE OF DEATH* was as follows:

Cysticercus of Stomach

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 3/22/29

Was there an autopsy? No

What test confirmed diagnosis? Microscopic Examination

4/12 (Signed) R. H. Wood, M. D.

1929 (Address) Bon Ton Hotel

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Trinity R.C. Cem

DATE OF BURIAL 4/15 1929

20 UNDERTAKER Wm Fiaesfowerk

ADDRESS 1618 Eastern Ave.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45033
1-PLACE OF DEATH

CERTIFICATE OF DEATH

90 E 45033
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of Baltimore: (No. 693 W. Mulberry St., 4-25 Ward)

2-FULL NAME Robert Wheeler

(a) RESIDENCE NO. 693 W. Mulberry St., Ward
(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 1855

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	73	7		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Janitor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Washington D.C.

PARENTS

10 NAME OF FATHER Robert Wheeler (Sr)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary M. Williams

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Joseph Wheeler
(Address) Lacostik Va

APR 14 1929

C. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest
(Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Chronic Myocardial Insufficiency

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zeller, M. D.

4/14. 1929 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cem Hyatts D.C.

20 UNDERTAKER H.E. Jarvis & Co

DATE OF BURIAL 4/16 1929

ADDRESS 2222 Georgia ave N.W. Washington D.C.

WRITE PLAINLY, with lead pencil or pen and ink. Do not use abbreviations. This certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45034

CERTIFICATE OF DEATH

90 E 45034

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 2819 Harlem Ave ST., 16-69 WARD)

2—FULL NAME Eugene B. Smith

(a) RESIDENCE NO. 2819 Harlem Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 7 mos. 9 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hellen A. Smith

6 DATE OF BIRTH (month, day, and year) Sept 3rd 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66.	7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Mrs. Hellen A. Smith.

(Address) 2819 Harlem Ave

15 APR 14 1929 C. HARRISON JONES, M. D. 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 12th 1929.

17

I HEREBY CERTIFY, That I attended deceased from January 1, 1929, to April 12, 1929.

that I last saw him alive on April 12 1929

and that death occurred, on the date stated above, at 5.30 P. m.,

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Acute cardiac dilation

(duration) yrs. mos. 1 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John C Kemp, M. D.

4 13 1929 (Address) 904 N Charles st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	Apr 15 1929
20 UNDERTAKER	ADDRESS
J. F. Cowan Sons	W. Holland St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

45035

CERTIFICATE OF DEATH.

9r E 45035

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 15-61 Ward

2-FULL NAME Wm Price

(a) RESIDENCE NO. 3615 Springdale Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? 16 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Edith Price

6 DATE OF BIRTH (month, day and year): July 7 1885

7 AGE — Years: 45 Months: Days: IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Electrician

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country): Austria

PARENTS

10 NAME OF FATHER: Samuel

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Austria

12 MAIDEN NAME OF MOTHER: Fanny Singer

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Austria

14 Informant: Jack Louis

(Address): 1439 E Baltimore

15 Filed APR 14 1929 G. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (~~Month, Day and Hour~~): Apr 13. 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Instantly caused by Electrocution

Coronary Thrombosis

Contributory (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) (Coroner) M. D.

4/13, 19 29 (Address) 1639 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Hill Date of Burial 4/15 19 29

20 UNDERTAKER: Jack Louis ADDRESS 1439 E Balto St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45036

CERTIFICATE OF DEATH.

49 E 45036

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hosp. ST. 1300 Al WARD)

2-FULL NAME Charles L. Lazarus.

(a) RESIDENCE No. 2215 Brookfield Ave ST., WARD A11

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Widower

5a If married, widowed, or divorced HUSBAND (of) (or) WIFE of Matilde Lazarus

6 DATE OF BIRTH (month, day, and year) Feb 1-1868

7 AGE Years 61 Months 2 — 1 Days 11 — 12 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York City

PARENTS

10 NAME OF FATHER Solomon Lazarus

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Augusta

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Sol Lazarus

(Address) 2215 Brookfield Ave

C. HAMPSON JONES, M. D.

Registrar

APR 14 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/11 1929

17 I HEREBY CERTIFY, That I attended deceased from 2/11, 1929, to 4/11, 1929, that I last saw h alive on 4/10, 1929, and that death occurred, on the date stated above, at 9:30 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rt. Lung

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) A. A. Gilbert, M. D.

4/11, 1929 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship

DATE OF BURIAL 4/14 1929

20 UNDERTAKER Jack Lewis

ADDRESS 1739 E. Baltimore St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45037

CERTIFICATE OF DEATH.

E 45037

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 408 Venable Ave. St. 17-50 WARD)

2-FULL NAME Delia E. Bauer

(a) RESIDENCE NO. 408 Venable Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. 8 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Bauer

6 DATE OF BIRTH (month, day, and year): July 22-1865

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
63	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Benjamin Reed

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Agnes Yolandt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Miss Katherine Bauer, 408 Venable Ave

15 C. HAMPSON JONES, M. D., Registrar

Per

R 14 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 12/29 19

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 —, 1929, to Apr 12/1929, that I last saw h— alive on Apr 11/, 1929, and that death occurred, on the date stated above, at 6.45 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Stomach. Abdt 1 yr.

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W S Willett M. D.

(Address) 2220 Harrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: Apl. 15, 1929.

20 UNDERTAKER: Elmer N. Conklin, — ADDRESS: 924 E. Eager St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45038

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 45038

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3516 Roland Ave ST., 13 WARD)

REGISTERED NO. 57

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rosina F. Stevens

(a) RESIDENCE NO. 3516 Roland Ave ST., 13 WARD
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Daniel K. Stevens

6 DATE OF BIRTH (month, day, and year) Feb. 18-1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Co. Md

PARENTS

10 NAME OF FATHER Joseph Gladdetter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Rebecca Brow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Miss Nina L. Cutler

(Address) 3814 Roland Ave

15 HAMPSON JONES, M. D.
Registrar

APR 14 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13-1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 15 1929, to April 12, 1929, that I last saw h[er] alive on April 12, 1929 and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C. T. Gatzert, M. D.

, 19 (Address) 243 S. Paca St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Moriah Cemetery — DATE OF BURIAL April 15 1929

20 UNDERTAKER Horace M. Burgee — ADDRESS 1631 Falls Road

IMPORTANT. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45039 E 45039

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4901 Hutton Ave. ST., 28-66 WARD)

2-FULL NAME Ruth L. Gordon

(a) RESIDENCE NO. 4901 Hutton Ave ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 83 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John N. Gordon

6 DATE OF BIRTH (month, day, and year) Feb. 11, 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	82	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Calvb. Stinchcomb

11 BIRTHPLACE OF FATHER (city or town) Not Known
(State or country)

12 MAIDEN NAME OF MOTHER Rachael R. Barnett

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Md.

14 Informant Miss Gertrude G. Gordon
(Address) 4901 Hutton Ave.

APR 14 1929

(Date received) C. HAMPSON JONES, M. D.
Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13. 1929.

17 I HEREBY CERTIFY, That I attended deceased from Sept 23 1928 to April 12 1929
that I last saw h alive on April 14 1929
and that death occurred, on the date stated above, at 12.30 A m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Trouble

(duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Valvular Heart Trouble (durnation) — yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo L Eberhart M. D.

19 (Address) Woodlawn P.O. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Park Cemetery

DATE OF BURIAL Apr. 15 1929

20 UNDERTAKER John F. Denny

ADDRESS 715 Light St.

CAUSE OF DEATH to plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

Curtis Bay

E 45040

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 45040

1 PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Curtis Creek + Pennington Ave ST. 25 T WARD)

2-FULL NAME Emma E Foote

(a) RESIDENCE No. Curtis Creek + Pennington Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Foote

6 DATE OF BIRTH (month, day, and year): (illegible)

7 AGE — Years: about 75 yrs. Months: Days: If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 03

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country): Don't Know

12 MAIDEN NAME OF MOTHER: Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Don't Know

14 Information Given by: Mrs Agnes Johnson (Address) Curtis Creek + Pennington Ave

15 Filed: C. HAMPSON JONES, M. D. Registrar

PR 141929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 13 1929

17 I HEREBY CERTIFY, That I attended deceased from Mar. 1st, 1929, to Apr. 13, 1929.

that I last saw h alive on Apr. 12, 1929

and that death occurred, on the date stated above, at 11 a. m

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W. [illegible] M. D.

(Address) 816 Pennington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Marley Church Cemetery

DATE OF BURIAL: April 13 1929

20 UNDERTAKER: John F Denny

ADDRESS: 715 Light St

Spec. -7-17-26—A Co.—200 Bks.

45041

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

118-002 ✓

E 45041

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital 16-67 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis Shores

(a) RESIDENCE NO. 3209 Brighton St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 7 - 1923

7 AGE	Years	Months	Days	1F LESS than 1 day hrs. or min..
	6	3	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER William Irvy Shores

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Elsie Allen

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Washington

14 Informant Mrs Elsie Shores

(Address) 3209 Brighton St

APR 17 1929

C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/13/29 19

17 I HEREBY CERTIFY, That I attended deceased from 4/12/29, 19 to 4/13/29, 19,

that I last saw h[illegible] alive on 4/13/29, 19,

and that death occurred, on the date stated above, at 5 [illegible] m.

The CAUSE OF DEATH* was as follows:

Strangulation of Bowel

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Operative Shock

(duration) yrs. mos. 1/2 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of 4/12/29

Was there an autopsy?

What test confirmed diagnosis? Operation

(Signed) [illegible], M. D.

. 19 (Address) Mercy Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Bells Church Camp Springs Maryland April 15 1929

20 UNDERTAKER ADDRESS

Josiah Syfer 1600 N. Roll Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45042

CERTIFICATE OF DEATH

129

E 45042

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2030 Park Avenue ST. 13-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edmund Joseph Webb

(a) RESIDENCE NO. 2030 Park Avenue ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 77 yrs. 7 mos 25 ds. How long in U. S., if foreign birth 77 yrs. 7 mos 25 ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Aug-18-1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	7	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Edmund G. Webb

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Sydney Augusta Kelso

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14

Informant Mrs. R. DeP. Webb

(Address) 2030 Park Avenue.

Filed APR 14 1929, 19 S. HANSON JONES, M. D.
Registrar

important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/13/29

17

I HEREBY CERTIFY, That I attended deceased from May, 1928, to 4/12, 1928.

that I last saw h[illegible] alive on 4/12, 1928

and that death occurred, on the date stated above, at 5 9 m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Toxic[illegible] Sinusitis

death (duration) yrs. 1 mos. 18 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Laboratory findings

(Signed) W. B. Hubert, M. D.

4/13, 1929 (Address) 1403 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL Apr-15-29 19

20 UNDERTAKER [illegible] & MOWEN COMPANY
[illegible] WOODLAWN, Sub-[illegible]

ADDRESS 103 W. NORTH [illegible]

Spec.—2-29-28—L. F. S.—500 Bks.

224018 E45043

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 92 E 45043

1—PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Nathan W Ritter

(a) RESIDENCE (Usual place of abode) Schuylkinny Pa. ST., ... WARD

Length of residence in city or town where death occurred ..... yrs. ..... mos. 11 ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) 7-1-90

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	38	9	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work clerk

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER Henry Ritter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa.

12 MAIDEN NAME OF MOTHER Ellen M Moyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Records.

(Address) JOHNS HOPKINS HOSPITAL

15 Filed APR 15 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14-29

17 I HEREBY CERTIFY, That I attended deceased from April 3, 1929, to April 14, 1929, that I last saw him alive on April 14, 1929 and that death occurred, on the date stated above, at 6 20 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary embolus

(duration) ..... yrs. ..... mos. 30 min. ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of Apr. 1, 1929

Was there an autopsy? Yes.

What test confirmed diagnosis? .....

(Signed) E E Jones M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sunbury Pa

DATE OF BURIAL 4/17/29

UNDERTAKER Joseph Ahrens

ADDRESS 221 Bway

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45044 CERTIFICATE OF DEATH. **E 45044**

REGISTERED NO. 129

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No. ..... St., ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Harry Steinberg

(a) RESIDENCE NO. 214 Aisquith St., ... Ward

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	W.	M.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie

6 DATE OF BIRTH (month, day, and year) 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	78	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Aaron Steinberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rachel ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Abe Stein

(Address) 435 Aisquith St.

15 C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14 1929

17 I HEREBY CERTIFY, That I attended deceased from April 11, 1929, to April 14, 1929, that I last saw h alive on April 14, 1929, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Uremia

Chronic Interstitial Nephritis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Hypertrophy of Prostate Gland (duration) 11 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Frederick S. Wolf, M. D.

4-14-1929 (Address) Sinai Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale — DATE OF BURIAL 4/15 1929

20 UNDERTAKER Sol Levinson & Bro — ADDRESS 1127 E Balto st

APR 15 1929

Death should be carefully supplied. AGE should be stated EXACTLY. If CHILDS should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45045 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓ **E 45045**

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1132 Myrtle Ave 7-25 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sarah J. Peck

(a) RESIDENCE NO. 1132 Myrtle Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 80 yrs. mos. 8 ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Norristown
(State or country) Pa.

PARENTS

10 NAME OF FATHER Samuel Cross

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Norristown Pa.

12 MAIDEN NAME OF MOTHER Anna Williams

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Norristown Pa.

14 Informant Walter P. Peck

(Address) 1132 Myrtle Ave

Filed APR 15 1929, 19 Per C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/11/29

17 I HEREBY CERTIFY, That I attended deceased from 11/16/28, 19 to 4/11/29, 19
that I last saw h[illegible] alive on 4/16/29, 19
and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. B. Hawkins M. D.

4/17, 19 29 (Address) 917 Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	April 15 1929
20 UNDERTAKER Charles G. Cooper	ADDRESS 514 Eastern Ave.

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45046

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

46 E 45046

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hos ST., 9-4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Bessie Curtis

(a) RESIDENCE NO. 1734 - E. 30th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Curtis

6 DATE OF BIRTH (month, day, and year) March 25, 1867

7 AGE — Years: 62 | Months: 0 | Days: 19 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Talbot Co Md.

PARENTS

10 NAME OF FATHER Robt. D. Kinnamon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Josephine LaCombe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mr. Richard F. Hughes.

(Address) 440 Groveland Ave.

15 Filed APR 15 1929 C. J. [illegible] Registrar

R 151929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 20, 1929, to April 13, 1929, that I last saw h— alive on April 13, 1929 and that death occurred, on the date stated above, at 1:50 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of left breast

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinomatosis of abdominal viscera (duration) 3 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? Yes Date of March 20, 1929

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination.

(Signed) Lewis P. Tyndray, M. D.

4/13, 1929 (Address) University Hospital

*State the Disease Causing Death, or if deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pikesville Md. DATE OF BURIAL: Apl. 15 1929

20 UNDERTAKER: W. M. Pickner Sons. ADDRESS: North & Pa

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 45047 CERTIFICATE OF DEATH

90 E 45047

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 1130 McCulloh St. (WARD) H-24

2-FULL NAME Estella Smead or Steed

(a) RESIDENCE NO. 1130 McCulloh ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Chas - Smead

6 DATE OF BIRTH (month, day, and year): Not known

7 AGE: Years 35 Months 10 Days 4 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 37

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland -

PARENTS

10 NAME OF FATHER: Wm Dryden

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland -

12 MAIDEN NAME OF MOTHER: Ellen London

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland -

14 Informant: Ellen Mahoney

(Address) 127 Collier Alley

15 Filed 4-15-29 C. HAMPSON JONES, M.D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 13th 1929

17 I HEREBY CERTIFY, That I attended deceased from April 10 1929, to April 13 1929, that I last saw h[illegible] alive on April 17 1929 and that death occurred, on the date stated above, at 8 a — m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

CONTRIBUTORY (Secondary) Acute Bronchitis (duration) yrs. mos 3 ds.

18 Where was disease contracted if not at place of death? Residence (duration) yrs. mos. 7 ds.

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Samuelle Dain M. D.

19 (Address) 937 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL 4-15-1929

UNDERTAKER: Dennis Carson ADDRESS 916 Cam

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 45048

REGISTERED NO. E 45048

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

E 45048

1-PLACE OF DEATH

City of Baltimore: (No. 1111 Maryland St., 18-N Ward)

2-FULL NAME James Hacket

(a) RESIDENCE NO. 1009 Sarah St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~~yrs.~~ ~~mos.~~ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	45			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Unknown
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Bernard Johnson
(Address) 344 Pratt St.

15 Filed ..... 19.. ..... Registrar

APR 13 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9- 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry) find that said deceased came to Hes death on the day stated above.
The CAUSE OF DEATH was as follows:
Homicide
Stab Wound of Chest
(duration) ..... yrs. ..... mos. 2hrs ds.
CONTRIBUTORY (Secondary) Shock
(duration) ..... yrs. ..... mos. ..... 2 ds.

18 Where was disease contracted —
If not at place of death?
Did an operation precede death? — Date of —
Was there an autopsy? Yes
What was confirmed diagnosis?
Dr. Guy C. Glades, M. D.
(Address) 1430 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	April 15- 1929

20 UNDERTAKER John D. Stevens
ADDRESS 1813 N. Fulton Ave.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45049

CERTIFICATE OF DEATH

11-001

E 45049

REGISTERED NO. 25-32

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2170 Nicomico ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Kenneth Wheeler

(a) RESIDENCE NO. 2170 Nicomico ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) December 17" 1927

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland U S

PARENTS

10 NAME OF FATHER Charles Wheeler

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Selina Price

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mrs. Selina Wheeler
(Address) 2170 Nicomico St

15 [illegible] Registrar

APR 15 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 13" 1929

17 I HEREBY CERTIFY, That I attended deceased from 4/10/29, 19..., to 4/13, 19..., that I last saw h... alive on 4/13/29, 19..., and that death occurred, on the date stated above, at 5:15 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

CONTRIBUTORY (Secondary) Grippe (duration) ... yrs. ... mos. 2 ds.

(duration) ... yrs. ... mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Theodore Dann, M. D.

, 19 (Address) 2170 Nicomico St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL Mch. 15 1929

20 UNDERTAKER Robert Cook — ADDRESS 1003 W. Baltimore St

IMPORTANT. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45050

1-PLACE OF DEATH

CERTIFICATE OF DEATH

E 45050

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of Baltimore: (No.) Frankentown St. 28-65 (Ward)

2-FULL NAME Herman F Arndt

(a) RESIDENCE NO. Frankentown Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: May Arndt

6 DATE OF BIRTH (month, day, and year): July 30-1872

7 AGE: Years 56 | Months 8 | Days 14 | IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Steam driller
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town): Germany
(State or country)

PARENTS

10 NAME OF FATHER: Fred Arndt

11 BIRTHPLACE OF FATHER (city or town): Germany
(State or country)

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town): Germany
(State or country)

14 Informant: May Arndt
(Address) Frankentown

15 Filed APR 15 1929 C. HAMPSON JONES, M. D. Registrar
Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): April 13th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Apoplexy (duration) yrs. Sudden

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) April 13th 1929 Harry Hoffstick, M. D. Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Catonsville — DATE OF BURIAL: April 16 1929

20 UNDERTAKER: D. D. Bork — ADDRESS: 1003 Pratt St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45051

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 45051

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 1922 McElderry St., 7-4 WARD)

2—FULL NAME John Lewis

(a) RESIDENCE NO. (Usual place of abode) 1922 McElderry St., WARD

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Fannie Lewis

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE: Years 56; Months —; Days —; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tailor

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Benj Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Elerin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Fannie Lewis

(Address) 1922 McElderry St

15 Filed: C. HAMPSON JONES, M. D. Registrar

C 15 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/15/29

17 I HEREBY CERTIFY, That I attended deceased from 1925 to April 14 1929.

that I last saw him alive on April 14 1929

and that death occurred, on the date stated above, at 12 00 A. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Degeneration

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. K. Hellman, M. D.

4/15 1929 (Address) 1504 Bentalou St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mehrem Rosedale

DATE OF BURIAL: 4/15 1929

20 UNDERTAKER: Jacob Lewis

ADDRESS: 1439 E. Balto St

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Alvey 90

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45052

CERTIFICATE OF DEATH

E 45052

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1804 Rosedale ST. 15-67 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Helen Leah Alvey

(a) RESIDENCE NO. 1804 Rosedale ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 4 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38	8	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER C. Hardy Armstrong

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Eliza Leah

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant C. Hardy Armstrong

(Address) Lindbrook Park

Filed APR 15 1929, 19 ANTHONY J. JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 12/29.

17 I HEREBY CERTIFY, That I attended deceased from April, 1929, to Apr. 12, 1929.

that I last saw her alive on Apr 12, 1929

and that death occurred, on the date stated above, at 8 m.

The CAUSE OF DEATH* was as follows:

myocarditis -

arteriosclerosis -

About

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wilbur Rutkatt, M. D.

Apr 13-29, 19 (Address) 2220 Garrison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet	Apr 15 1929
20 UNDERTAKER George J. Smith	ADDRESS 153 L Hollins

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

4286

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45053

CERTIFICATE OF DEATH

100-00

E 45053

1—PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

CITY OF BALTIMORE: (No. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Mc Corkle

(a) RESIDENCE NO. 905 Jordan St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 ~~Single, Married, Widowed, or Divorced, (write the word)~~: Baby

6 DATE OF BIRTH (month, day, and year): Dec 31 1927

7 AGE: Years 1 Months 4 Days 9. If LESS than 1 day, hrs. or min.

16 Mos

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: William Mc Corkle

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Gertrude Cole

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Guardian

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 12 1929

17 I HEREBY CERTIFY, That I attended deceased from April 11 1929 to April 12 1929, that I last saw h alive on April 12 1929 and that death occurred, on the date stated above, at 4:27 P m.

The CAUSE OF DEATH* was as follows:

Coming bronchopneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumococcus septicemia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Dawson Mc Cune, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	Apr. 14 '29
20 UNDERTAKER: Mrs R. G. Elliott	ADDRESS: 925 Ashland Ave

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45054 **E 45054**

CERTIFICATE OF DEATH.

101-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 913 Plum (ST.) 23-31 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Goardley.

(a) RESIDENCE NO. 913 Plum ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs 7 mos. 20 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug. 24. 1906

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
22	7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer, gen

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: National Covenant Co

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Walter Goardley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Maryland

12 MAIDEN NAME OF MOTHER: Ida Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country): St Louis Missouri

14 Informant: Charles Goardley

(Address): 913 Plum St

15 Filed APR 5 1929

C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/13 1929

17

I HEREBY CERTIFY, That I attended deceased from 4/9, 1929, to 4/13, 1929,

that I last saw him alive on 4/12, 1929,

and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Acute Gastritis

Pneumonia

(duration) — yrs. — mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Dan Grunkin, M. D.

4/13, 1929 (Address) 1212 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion Ct

DATE OF BURIAL: April 16 1929

20 UNDERTAKER: H. L. Brandt Son

ADDRESS: 1200 Mary

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45055

CERTIFICATE OF DEATH

E 45055

REGISTERED NO. 57

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Church Home & Infirmary

City of BALTIMORE: (No. 1261 Broadway St., 14-20 Ward)

2-FULL NAME Mrs Sarah Wallerstein

(a) RESIDENCE NO. 903 W North ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 26 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth 76 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Getzel Wallerstein

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE: Years 75 | Months | Days | IF LESS than 1 day..... hrs. or..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Russia

(State or country)

PARENTS

10 NAME OF FATHER: Joseph Michael

11 BIRTHPLACE OF FATHER (city or town): Russia

(State or country)

12 MAIDEN NAME OF MOTHER: Lotta Sluka

13 BIRTHPLACE OF MOTHER (city or town): Russia

(State or country)

14 Informant: L M Ainsworth

(Address) 1705 E Balto St

15 Filed ..... 19..... [illegible] Registrar

1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 15 1929

17

I HEREBY CERTIFY, That I attended deceased from Feb 16 1929 to Apr 15, 1929, that I last saw h[illegible] alive on Apr 15, 1929, and that death occurred, on the date stated above, at 2.45 p.m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus 10 yrs ?

Diabetic Gangrene 3 yrs

Endarteritis Obliterans - Chr Nephritis

Hypertension (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBITORY (Secondary) Cardiac Failure

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Dan B Peters M. D.

4/15, 1929 (Address) Church Home & Infirm

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Mach Lood — Date of Burial 4/15 1929

20 UNDERTAKER: Jack Lewis — ADDRESS 1739 E Balto St

For Board of Charity Register. Age should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45056

CERTIFICATE OF DEATH

E 45056

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Univ Md St 21-24 Ward)

2-FULL NAME James E. Bell

(a) RESIDENCE NO. 417 S Scott St., Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Leona M Bell

6 DATE OF BIRTH (month, day, and year) Sept 27 1892

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
36	6	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER Harry Bell

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Rose Hough

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md.

14 Informant Leona M Bell
(Address) 417 S Scott St

Filed 10-29 1929 C. HAMPSON JONES, M. D.
Registrar

PN 151929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 12 1929

17 I HEREBY CERTIFY that I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. mos. — ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. — ds.

18 Where was disease contracted if not at place of death? 417 S Scott

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Clinical History

(Signed) W C Eliades M. D.

19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL 4-16 1929

20 UNDERTAKER Bernard C Harr — ADDRESS 1000 S Pach.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 45057

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

5-2

E 45057

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. U.S. Marine Hospital ST. 9-4½ WARD)

2-FULL NAME Birt Williams

(a) RESIDENCE No. 2708 Boone Street, Baltimore, Md WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rebecca Williams

6 DATE OF BIRTH (month, day, and year) Sept. 19, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	5	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) Seaman

(c) Name of employer U.S. Infantry (U.S.Govt.)

9 BIRTHPLACE (city or town) (State or country) Illinois

PARENTS

10 NAME OF FATHER Finis Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kentucky

12 MAIDEN NAME OF MOTHER Leila Tucker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kentucky

14 Informant Records, U.S. Marine Hospital (Address) Baltimore, Md.

15 Filed ..... 19 ..... HAMPSON JONES, M. D. Registrar

By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12 1929

17

I HEREBY CERTIFY, That I attended deceased from April 12 .19 29. to April 12 .19 29.

that I last saw him alive on April 12 .19 29,

and that death occurred, on the date stated above, at 6:40 P.m.

The CAUSE OF DEATH* was as follows:

Arthritis deformans

O.K. Coroner J. J. Thomsen

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Laboratory

(Signed) Ralph L Porter M. D.

4/13 19 29 (Address) U.S. Marine Hospital, Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore

DATE OF BURIAL 4/15 1929

20 UNDERTAKER Wm Cook

ADDRESS 1217 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PR 151929

Spec.—2-29-28—L. F. S.—500 Bks.

Hook Dr Monatiord 25th Barclay

E 45058 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129

REGISTERED NO. E 45058

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2121 St Paul ST. 12-50 (WARD)

2—FULL NAME Johnsey W. Hook

(a) RESIDENCE NO. 2121 St Paul ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6 a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary E Hook

6 DATE OF BIRTH (month, day, and year): Dec 13, 1841

7 AGE — Years: 87 | Months: 4 | Days: | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer, Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Oak

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Co. Md

PARENTS

10 NAME OF FATHER: Randolph Hook

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Co Md

12 MAIDEN NAME OF MOTHER: Mary Watts

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Co Md

14 Informant: Frank K Hook

(Address) 212 St Paul St

15 Filed APR 15 1929 Per

C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 13, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 3rd, 1929, to April 13th, 1929, that I last saw h[illegible] alive on April 12th, 1929 and that death occurred, on the date stated above, at 2.0[illegible] m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam

(Signed) Geo Pfeiffer III M. D.

4/14/1929 Address 401 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mid Ridge

DATE OF BURIAL: 4/15 1929

20 UNDERTAKER: J M Cook

ADDRESS: 1217 St Paul St

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

45059 Randall

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001 E 45059

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 34 E. Hamburg ST. 24-35 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Catherine S. Randall.

(a) RESIDENCE NO. 34 E. Hamburg ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 73 yrs. 3 mos. 19 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White.	Widowed.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas E. Randall.

6 DATE OF BIRTH (month, day, and year) Dec. 24, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73.	3.	19.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home. G.D

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John A. Swan.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mary A. Everhardt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Mr. Randall, (Son).

(Address) 34 E. Hamburg St.

15 Filed C. HARRISON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13 1929.

17 I HEREBY CERTIFY, That I attended deceased from March 22, 1929, to April 13, 1929, that I last saw h[illegible] alive on April 12, 1929 and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 23 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) W. H. Campbell M. D.

4/17, 1929 (Address) 644 Hamburg St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Pk Cem DATE OF BURIAL April 16, 1929

20 UNDERTAKER A. Hamil Evans ADDRESS 38 E Fort Ave

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45060

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45060

CERTIFICATE OF DEATH

129

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

CITY OF BALTIMORE: (No. [redacted] ST. 17-25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Nick Perry

(a) RESIDENCE NO. 616 Foster ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Negro

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Perry

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: 70 | Months: | Days: | If LESS than 1 day, ...hrs. or ....min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of Industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Nick Perry

11 BIRTHPLACE OF FATHER (city or town) (State or country): North Carolina

12 MAIDEN NAME OF MOTHER: Annie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): North Carolina

14 Informant: Records of

(Address) BALTIMORE CITY HOSPITALS

15 Filed [illegible], 19 THOMPSON JONES, M. D. Registrar

15152 [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-5-29

17 I HEREBY CERTIFY, That I attended deceased from November 15, 1928 to 4-5, 1929, that I last saw h[illegible] alive on 4-5, 1929 and that death occurred, on the date stated above, at 2:15 m.

The CAUSE OF DEATH* was as follows:

Tuberculous Heart disease & nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiosclerosis, Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam. Urine exam

(Signed) Harry M. McLean, M. D.

, 19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

APR 15 1929

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45061

CERTIFICATE OF DEATH

90

REGISTERED NO. E 45061

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Jail ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry McCauley

(a) RESIDENCE NO. 1954 W Fay ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE — Years: 54 — Months: — Days: — If LESS than 1 day, hrs. or mln.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant

(Address)

15 Filed APR 15 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/9/29

17 I HEREBY CERTIFY, That I attended deceased from 3/15, 1928, to 4/9, 1929, that I last saw h[illegible] alive on 4/9, 1929, and that death occurred, on the date stated above, at 8:10 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Gastritis

Asthenia

Chr. Myocarditis

Duration yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

Duration yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Jail

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) A. J. McCosh M. D.

19 (Address) Baltimore Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

UNDERTAKER Dept Dissolect Health.

ADDRESS

APR 15 1929

important. See instructions on back of certificates.

UNIVERSITY OF MARYLAND

PR 15 1929

THE MORGUE

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45062 CERTIFICATE OF DEATH

21 E 45062

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore ST. 27 WARD) REGISTERED NO. 27 41

2—FULL NAME John McKay

(a) RESIDENCE NO. 108 Gunther ST., WARD
(Usual place of abode)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Jas. McKay

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Hannah Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant

(Address)

15 Filed APR 15 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/13/29

17 I HEREBY CERTIFY, That I attended deceased from 4/3/29, 19, to 4/13, 19 29, that I last saw h alive on 4/13, 19 29 and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Empyema, T
Acute

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. M. Hurd, M. D.

, 19 (Address) Baltimore City

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER (Name Discontinued by Health Dept.)

ADDRESS

APR 15 1929

Important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45063

100-001

CERTIFICATE OF DEATH.

E 45063
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 815 West Lombard St. St. 18-24 Ward)

2-FULL NAME Samuel McCarty

(a) RESIDENCE NO. 815 West Lombard St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Stella Mc Carty

6 DATE OF BIRTH (month, day, and year) Aug 10th 1880

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	48	8	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Scranton

(State or country) Pa.

PARENTS

10 NAME OF FATHER Mr. Mc Carty

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Stella Mc Carty

(Address) 815 West Lombard St.

Filed APR 15 1929 H. HANSON JONES, M. D. Registrar

Par

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14th. 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Oedema of Lungs

(Duration) yrs. mos. ds.

(Signed) (Coroner) M. D.

4/14 1929 (Address) 149 North Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

15 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Hill Cemetery Date of Burial Apr 16th 1929

20 UNDERTAKER Wm F. Cowan & Son ADDRESS 901 Hollins St.

DIRECTIONS.—Every question on this certificate must be answered. If the information required cannot be ascertained, the reason should be stated. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45064
1—PLACE OF DEATH

CERTIFICATE OF DEATH

31

E 45064
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1634 Normal Ave ~~St~~ WARD) 8-45

2—FULL NAME Sylvester E Funk

(a) RESIDENCE NO. 1634 Normal Ave ~~St~~. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (~~or WIFE of~~) Nellie Funk.

6 DATE OF BIRTH (month, day, and year) May 3, 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	55.	10	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk. Gd 9
(b) General nature of industry, business, or establishment in which employed (or employer) Grocery.
(c) Name of employer Hollock Bro

9 BIRTHPLACE (city or town) (State or country) Balt.

PARENTS

10 NAME OF FATHER August Funk.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER ~~Mary~~ Katie Krauss.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Fannie M. Funk.
(Address) 1634 Normal ave.

FILED APR 15 1929, 19 ... Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 5, 1929, to April 13, 1929.
that I last saw him alive on April 12, 1929
and that death occurred, on the date stated above, at 6.15 A m.
The CAUSE OF DEATH* was as follows:
Lobar Pneumonia
(Pulmonary)

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical

(Signed) Frederick D. Mack, M. D.
, 19 (Address) 827 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	April 16 1929.

20 UNDERTAKER ADDRESS
George L. Ruth 1735 Harford ave

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45065

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

CERTIFICATE OF DEATH

E 45065

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 403 Maryland Av ST. Greenmount 27-48 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret Steinmann

(a) RESIDENCE NO. 403 Maryland Av ST., WARD

(Usual place of abode) (If non-resident give City or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

6a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: the late Albert Steinmann

6 DATE OF BIRTH (month, day, and year): October 28 1887

7 AGE: Years 41 | Months 0 | Days 16 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

037

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Charles Yoe

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Catherine Callahan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs. Catherine Yoe

(Address) 403 Maryland Av

15 Filed APR 15 1929, 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 14 1929

17 I HEREBY CERTIFY, That I attended deceased from Apr 13, 1929 to Apr 13, 1929, that I last saw h alive on Apr. 14 and that death occurred, on the date stated above, at 12.40 A.M. 1929

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) 2 hours yrs. mos. ds.

CONTRIBUTORY (Secondary): Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? on the street

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. H. Duncan, M. D.

Apr 14, 1929 (Address) 5104 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: Apr. 16 1929

20 UNDERTAKER: Henry Troch Sons, Inc. — ADDRESS: 201 E Eager St

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 45066

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 45066

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Johns Hopkins Hospital St., 7-9 Ward)

2-FULL NAME Dorothy L. Kraft

(a) RESIDENCE NO. Wendover Road & Old Harford Ave St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. / ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F	W	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 8/28

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	1	0	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Ernst H. Kraft

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Mary M. Matthews

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto., Md.

14 Informant Ernst H. Kraft
(Address) Wendover Rd & Old Harford Rd

15 FILED APR 15 1929 19 HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 14/29

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (primary)

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. C. Kraft, M. D.

4/15/29 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery — DATE OF BURIAL April 16 1929

20 UNDERTAKER Henry Hoech Sons, Inc. — ADDRESS 1301 E Eager St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

APR 15 1929

Spec.—1-12-23—M&T—500 Blks.

Barry

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45067

CERTIFICATE OF DEATH.

91-002

E 45067

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor St. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James L Barry

(a) RESIDENCE NO. Preston & Valley ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 2nd 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER James L. Barry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Anna Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Little Sisters of the Poor (Address) Preston & Valley

15 Filed APR 15 1929 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13th 1929

17 I HEREBY CERTIFY, That I attended deceased from April 2nd, 1929, to April 13, 1929, that I last saw h~ alive on April 13, 1929, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) S. Hampson Jones, M. D.

(Address) 1206 N Calvert

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery DATE OF BURIAL 4/16 19 29

20 UNDERTAKER Chas R Braid Son ADDRESS 1810 N Rayal

TION is very important See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 45068

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

E 45068

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Bell City Hospital St. 1-3 Ward)

2-FULL NAME (Wojciech) George Milkowski

(a) RESIDENCE NO. 2733 Dillon St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? 25 yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Catherine Milkowski

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE: Years 44 | Months | Days | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Molder

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Central Foundry

9 BIRTHPLACE (city or town):

(State or country): Poland

PARENTS

10 NAME OF FATHER: Matthew Milkowski

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Poland

12 MAIDEN NAME OF MOTHER: Mary Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Poland

14 Informant: Frank Milkowski

(Address) 2733 Dillon

15 Filed.....19..... C. HAMPSON JONES, M. D.

Registrar

By.....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Central Lobar Pneumonia

(duration) .....yrs. .....mos. 6 ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) .....yrs. .....mos. .....ds.

(Signed) James M. Benton M. D.

(Coroner)

4 13 1929 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death 25 yrs. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? 2733 Dillon

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislaus Cem. Date of Burial: April 16 1929

20 UNDERTAKER: Stephen D. Tralkowski ADDRESS 1000 S. Kenwood Ave

Do not write in any space. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PR 15 1929

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45069

CERTIFICATE OF DEATH.

188-103 ✓

E 45069

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Franklin Square Hospital Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Donald L. Mallonee

(a) RESIDENCE NO. 1819 Walbrook Ave. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. 10 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 18 - 1920

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	8	10	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto. Md

PARENTS

10 NAME OF FATHER Lloyd L. Mallonee

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto Md

12 MAIDEN NAME OF MOTHER Margaret A. Kern

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto Md

14 Informant Father

(Address)

15 Filed ..... 19 C. HAMPSON JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/14 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows: Automobile Accident Fracture Skull

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. H. Brooke M. D.

(Coroner) Sup. Dist.

4/14 1929 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge — Date of Burial 4/16 1929

20 UNDERTAKER Geo. W. Settle — ADDRESS 2700 Edmondson Ave.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45070

CERTIFICATE OF DEATH.

197 E 45070

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospt. St. 11-7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William E. Judy

(a) RESIDENCE NO. 10 E. Hamilton St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred fifty yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 Color or Race: C.

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henetta Judy

6 DATE OF BIRTH (month, day, and year): 1887

7 AGE: Years 42; Months; Days; IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Balto.

(State or country): Md.

PARENTS

10 NAME OF FATHER: James Judy

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Md.

12 MAIDEN NAME OF MOTHER: Ida Gordon

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Md.

14 Informant: Louise Franklin

(Address): 10 E. Hamilton

15 Filed C. HARRISON JONES, M. D.

Per Registrar

151929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and hour): Nov 12 1929

17 I HEREBY CERTIFY, That I viewed the remains of the remains described above, held an autopsy (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said autopsy (Coroner, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows: Homicide

Gun shot wound, R leg

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. ds.

Witness my hand this 12 day of Nov 1929

(Coroner) M. D.

19 (Address) 1436 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary Date of Burial Nov. 14 1929

20 UNDERTAKER: Mrs. A. A. Elliott ADDRESS 1725 Eastlan

THE ABOVE MUST BE CAREFULLY FILLED IN and the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45071

CERTIFICATE OF DEATH

E 45071

1—PLACE OF DEATH

REGISTERED NO. 14-20 31

CITY OF BALTIMORE: (No.) Baltimore City Hospitals (ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Samson Jenkins

(a) RESIDENCE NO. 1728 S. Druid Hill ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Separated

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1898

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
31 ~~1898~~			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Wm. Jenkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Martha ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records (Address) 1313 Bayard St.

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12, 1929

17

I HEREBY CERTIFY, That I attended deceased from April 9 19 29, to April 12 19 29,

that I last saw him alive on April 12, 19 29

and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

Aortic insufficiency

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical and lab.

(Signed) Kenny C. Smith, M. D.

4-12 19 29 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lee St

DATE OF BURIAL 4/15 19 29

20 UNDERTAKER Samuel Hamsley

ADDRESS 538 N Bridge

Important. See instructions on back of certificates.

Joseph Jackins

C. HAMPSON JONES, M. D.

PR 151

Spec.—1-12-23—M&T—500 Blks.

E 45072

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45072

CERTIFICATE OF DEATH

1-PLACE OF DEATH Provident Hospital

CITY OF BALTIMORE: (No. 1514 Division St., 16-23 Ward)

3 REGISTERED NO. 101208

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Jenifer Smith

(a) RESIDENCE NO. 1213 St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Feb 5 - 1908

7 AGE: Years 21 Months 2 Days 7. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Montello, D.C.

PARENTS

10 NAME OF FATHER: James Jenifer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Jas. Jenifer (Address) 1213 St.

15 Filed Apr 13, 1929 C. HAMPSON JONES, M.D. Registrar

R 15[illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 12 1929

17 I HEREBY CERTIFY, That I attended deceased from Apr 9, 1929, to Apr 13, 1929, that I last saw h[illegible] alive on Apr 12, 1929, and that death occurred, on the date stated above, at 3 40 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Undetermined

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Bernard Harris M. D.

4/13, 1929 (Address) Provident Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem. DATE OF BURIAL: Apr 15 1929

20 UNDERTAKER: Samuel J. Kennedy ADDRESS: Mt. Belle

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 45073

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45073

CERTIFICATE OF DEATH

159-002

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 37 S. Bureley ST. 1-2 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Infant Jones

(a) RESIDENCE NO. 37 (Usual place of abode) S. Bureley ST. WARD

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Apl 5 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER William Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Maddie Brooks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mary Jones

(Address) 37 S. Bureley St

15 Filed C. THOMPSON JONES, M. D. Registrar

4/15/29

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 5, 1929, to April 15, 1929

that I last saw h alive on April 14, 1929

and that death occurred, on the date stated above, at 2 30 a m.

The CAUSE OF DEATH* was as follows:

Marasmus c pulmonary oedema

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Asphyxia pallida

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clin. data

(Signed) Lew Sollenger, M. D.

19 (Address) 304 E Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hawkins Md.

DATE OF BURIAL 4/15/1929

20 UNDERTAKER J. J. Doran

ADDRESS 300 E. Balto St.

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45074

CERTIFICATE OF DEATH

E 45074

1-PLACE OF DEATH

City of Baltimore: (No. 1408 Brunt St. 14-20 Ward)

REGISTERED NO. 101-001

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen Aydelotte

(a) RESIDENCE NO. 1408 Brunt St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred / yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Fem	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day and year) April 12th 1928

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	1	—	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Pocomoke
(State or country) Md.

PARENTS

10 NAME OF FATHER Jos. Aydelotte

11 BIRTHPLACE OF FATHER (city or town) Pocomoke
(State or country) Md.

12 MAIDEN NAME OF MOTHER Emma Sturgis

13 BIRTHPLACE OF MOTHER (city or town) Pocomoke
(State or country) Md.

14 Informant Jos. Aydelotte
(Address) 1408 Brunt St.

Filed ..... 19 THAMPSON JONES, JR. Registrar

APR 15 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) April 13th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The "CAUSE OF DEATH" was as follows:

Lobar Pneumonia

(duration) yrs. mos. 2d ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. C. Blair, M. D.
(Address) April 13 1929 Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem.	April 15. 1929
20 UNDERTAKER	ADDRESS
Mrs Geo. H. Holland	1631 Druid Hill Ave

IMPORTANT: Should be carefully supplied. Age should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 45075

90 **E 45075**

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3011 Hudson St., 4-3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Eliz. Bellmann

(a) RESIDENCE NO. 3011 Hudson St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 12 1851

7 AGE: Years 78 Months 3 Days 1

IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country) Md

PARENTS

10 NAME OF FATHER George Harrington

11 BIRTHPLACE OF FATHER (City or town):

(State or country) Balto Md

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town): Balto

(State or country) Md

14 Informant H. W. Bellmann

(Address) 3011 Hudson St

15 Filed C. HAMPSON JONES, M. D. Registrar

2151929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 13 19 29

17 I HEREBY CERTIFY, That I attended deceased from October, 19 27, to April, 19 29

that I last saw h alive on April 1, 19 29

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dilitation of Heart

(duration) yrs. mos. ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Joseph Tomlinson M. D.

19 (Address) 1500 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

Date of Burial: April 19 29

20 UNDERTAKER: Johannah & Sandow

ADDRESS: 1004 Linwood Ave

IMPORTANT—Should be entirely supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Gaildlose

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45076

CERTIFICATE OF DEATH

E 45076

1—PLACE OF DEATH

REGISTERED NO. 31

CITY OF BALTIMORE: (No. Baltimore City Hospitals, WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Flored Gaildlose

(a) RESIDENCE NO. 812 E Lombard ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) ~~WIFE~~ of

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Patient

(Address)

15 Filed ..... 19 C. HAMPSON JONES, M. D. Registrar

R 15 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/13/29

17

I HEREBY CERTIFY, That I attended deceased from 3-18, 1929, to 4-13, 1929, that I last saw h.m alive on 4-13, 1929 and that death occurred, on the date stated above, at 5-36 m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary tuberculosis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Lab. Path. Clinical

(Signed) Henry Smith, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Matthais

DATE OF BURIAL April 16 1929

20 UNDERTAKER Frank V. Pepitone

ADDRESS 2818 E. Baltimore St

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45077 X 38 **E 45077**

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 15-61

CITY OF BALTIMORE: (No. 3503 Fairview Ave ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harry J. Garrett

(a) RESIDENCE NO. 3503 Fairview Ave ST., WARD Wash. D. C.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pat Maker 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) D. C.

PARENTS

10 NAME OF FATHER William F. Garrett

11 BIRTHPLACE OF FATHER (city or town) (State or country) \

12 MAIDEN NAME OF MOTHER Julia G. Harvey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Lillian M. Carnahan

(Address) 3503 Fairview Ave Forest Park

15 Filed APR 15 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15 1929

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1929, to April 15, 1929, that I last saw h[illegible] alive on April 14, 1929 and that death occurred, on the date stated above, at 11 4 m.

The CAUSE OF DEATH* was as follows:

Cachymaningitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Tertiary Syph.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Clara Burns, M. D.

Apr 15 1929 (Address) 4 2 W Chesapeake Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Montgomery Co. Bellemeade Md

DATE OF BURIAL 4/15 1929

20 UNDERTAKER W. Z. Sands & Co

ADDRESS 412 N. Howard St. Balto. Md.

Important. See instructions on back of certificate.

4 15 1929

Spec.—2-29-28—L. F. S.—500 Bks.

E 45078

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

16-022

E 45078

REGISTERED NO. 151929

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1446 Lowson ST. 24-35 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Phyllis Ellen Aurer

(a) RESIDENCE NO. 1446 Lowson ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Apr 10 29

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	—	—	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) old

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Oscar Aurer

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Norway

12 MAIDEN NAME OF MOTHER Elizabeth Burke

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Elizabeth Burke
(Address) 1446 Lowson St

15 Filed ..... 19 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 15 29

17 I HEREBY CERTIFY, That I attended deceased from Apr 13, 19 29, to Apr 15, 19 29, that I last saw her alive on Apr 14, 19 29 and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Intracranial hemorrhage due to head injury at birth. delivery normal

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Path

(Signed) Wm Brady M. D.

Apr 15, 19 29 (Address) 1219 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem.

20 UNDERTAKER C. J. Thomas

DATE OF BURIAL April 16 29

ADDRESS 1534 Light St.

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45079

CERTIFICATE OF DEATH

90 E 45079

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 5203 Ready Ave ST. 27-48 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie Virginia Heim

(a) RESIDENCE NO. 5203 Ready Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm. Henry Heim

6 DATE OF BIRTH (month, day, and year) June 2. 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	87	3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Fredrick Md.

PARENTS

10 NAME OF FATHER Warner D. Kauffman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Fredrick Md

12 MAIDEN NAME OF MOTHER Sarah Little

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Fredrick Md

14 Informant Mrs. E. W. Reeder

(Address) 5203 Ready Ave.

15 Filed 6-19 1929 C. HAMPSON JONES, M. D. Registrar

R 15 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 3. 1929.

17 I HEREBY CERTIFY, That I attended deceased from March 31st 19 29 to April 3rd 19 29

that I last saw her alive on April 1st 19 29

and that death occurred, on the date stated above, at 7.40 A.m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) La Grippe

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Evidence

(Signed) Thomas Dorsey M.D. 1166 W. Fayette St. M. D.

4/5 19 29 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	4/6 19 29
20 UNDERTAKER C. Vernon Sommer	ADDRESS 501 E. 22 St.

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 45080

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 45080

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1044 N. Bond ST. 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles J. Wigman

(a) RESIDENCE NO. 1044 N. Bond ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret J. Wigman

6 DATE OF BIRTH (month, day, and year) Dec 15, 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	37	3	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shipper

(b) General nature of industry, business, or establishment in which employed (or employer) Bricklayer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Charles C. Wigman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Emma V. Hoffman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Margaret J. Wigman

(Address) 1044 N. Bond St

Filed Apr 15 1929 H. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 13/29.

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1929, to April 13, 1929, that I last saw h... alive on Apr 13/29 1929 and that death occurred, on the date stated above, at 9.15 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Physical Findings

(Signed) J. M. Dilatt M. D.

Apr. 15, 1929 (Address) 62 Wash. Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL Apr. 17th 1929.

20 UNDERTAKER Wm. J. Tufel & Son — ADDRESS 801 W. Fayette

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45081

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 100-02

E 45081

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. [illegible] ST. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME David Lussman

(a) RESIDENCE NO. 1916 Linden Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 18 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fanny L. Lussman

6 DATE OF BIRTH (month, day, and year) Jan 17-1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	3	3.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

066

9 BIRTHPLACE (city or town) (State or country) Pittsburg Pa

PARENTS

10 NAME OF FATHER Jacob Lussman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Holland

12 MAIDEN NAME OF MOTHER Anna

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Holland

14 Informant Records

(Address)

15 Filed ..... 19 HAMPSON L. JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-15-29

17 I HEREBY CERTIFY, That I attended deceased from 3-27, 1929, to 4-15, 1929, that I last saw h— alive on 4-15, 1929 and that death occurred, on the date stated above, at 11:10 A. m.

The CAUSE OF DEATH* was as follows:

Pemphigus Vulgaris

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Bronchial pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Biopsy

(Signed) Clark Bloom, M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pittsburg Pa — DATE OF BURIAL 4/16 19 29

20 UNDERTAKER Jack Lewis — ADDRESS 1409 E. Baltimore

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks. Desire V Neumann

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45082

CERTIFICATE OF DEATH.

E 45082
REGISTERED NO.

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No. Monument & Rutland St., 13-54 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Desire Neuman

(a) RESIDENCE No. 2235 Eutaw Place ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 6 mos. ds. How long in U. S., if of foreign birth? 2 yrs. 6 mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Goldberg Neumann

6 DATE OF BIRTH (month, day, and year) Sept 14-1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28	7	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hungary

PARENTS

10 NAME OF FATHER Emile Neumann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hungary

12 MAIDEN NAME OF MOTHER Hedwig Freid

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hungary

14 Informant Mary Goldberg Neumann
(Address) 2235 Eutaw Place

15 Filed 1929 G. HAMPSON JONES, Registrar
Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-14 1929

17 I HEREBY CERTIFY, That I attended deceased from 4-8, 1929, to 4-14, 1929, that I last saw him alive on 4-14, 1929, and that death occurred, on the date stated above, at 6.55 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary abscess

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 4-13-29

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Meyer Weiller, M. D.

4/14 1929 (Address) Sinai Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem. DATE OF BURIAL 4/16 1929

20 UNDERTAKER Josh Lewis ADDRESS 1439 E. Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

45083

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

E 45083

1—PLACE OF DEATH U. M. H

REGISTERED NO.

CITY OF BALTIMORE: (No. Calvert & 33 rd. ST. 13-54 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sheppard Soulsine

(a) RESIDENCE NO. 2008 Brookfield Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 13, 1913

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	16	2	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md

PARENTS

10 NAME OF FATHER Jacob Soulsine

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rose Aks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Hospital Records

(Address)

R 16 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 15, 1929

17

I HEREBY CERTIFY, That I attended deceased from Apr 14, 1929, to Apr 15, 1929, that I last saw h alive on April 15, 1929 and that death occurred, on the date stated above, at 10 35 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic

(durstion) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

4/15, 1929 (Signed) J. J. Geraghty, M. D.

(Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale

DATE OF BURIAL 4/16 1929

20 UNDERTAKER Joeh Lewis

ADDRESS 1439 E Balto St

Important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45084

CERTIFICATE OF DEATH.

E 45084

1-PLACE OF DEATH Franklin Square Hospital

City of BALTIMORE: (No. [illegible] St.) (Ward) 14-59

Registered No. C. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME. Ezekiel Mallonee

(Residence in Baltimore: No. 2261 Reisterstown Rd. St.; yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

6-DATE OF BIRTH. February 21, 1878
(Month) (Day) (Year)

7-AGE. 51 yrs. 1 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. See Business
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER. Ephria Mallonee

11-BIRTHPLACE OF FATHER, (State or Country). Balto Co

12-MAIDEN NAME OF MOTHER. Mary Ambrose

13-BIRTHPLACE OF MOTHER, (State or Country). Md

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary L. Mallonee

(Address) Balto Md

15- Filed APR 16 1929 19.. C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH.

16-DATE OF DEATH, Apr 15 1929
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) Chas H Wright M. D.
(Coroner.)

4/15 1929 (Address) Brooklyn Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury; and (2) whether Accidental, Suicidal, or Homicidal.

18-LENGTH OF RESIDENCE (For Hospitals, Institutions. Transients, or Recent Residents).
At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Druid Ridge — DATE OF BURIAL, April 18 1929

20-UNDERTAKER, Geo W Little — ADDRESS 2100 Edmondson

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45085

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001

E 45085

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3307 Edgerton Road ST. Ashburton, 15-62 WARD)

2—FULL NAME Emma C.Korff,

(a) RESIDENCE NO. 3307 Edgerton Road ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, or ~~Divorced~~, (write the word)
Female	White	Widow

a If ~~married, widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of Ferd C.Korff,

6 DATE OF BIRTH (month, day, and year) November 11.1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	5	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER August Conrades,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Augusta Hilleman,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Henry C. Korff

(Address) 3307 Edgerton Road,

15 Filed APR 16 1929 H. LAWSON JONES, M. D., Registrar

by

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY, That I attended deceased from Feb 11, 1929, to April 15th, 1929

that I last saw her alive on April 14th, 1929

and that death occurred, on the date stated above, at 8.10A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. G. Jones, M. D.

4/15, 1929 (Address) 720 No. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL 17 19

20 UNDERTAKER Geo W Little

ADDRESS

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

McConkey

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45086

CERTIFICATE OF DEATH

E 45086

1—PLACE OF DEATH

REGISTERED NO. 101

CITY OF BALTIMORE: (No. 636 Sarah Ann ST. 4-25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Wm. H. McConkey

(a) RESIDENCE NO. 636 Sarah Anna ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Colored	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 27 1911

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	17	3	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER Wm. H. McConkey

11 BIRTHPLACE OF FATHER (city or town) Balto, Md
(State or country)

12 MAIDEN NAME OF MOTHER Rose Lee Ramsey

13 BIRTHPLACE OF MOTHER (city or town) Balto, Md
(State or country)

14 Informant Isabelle Neall

(Address) 124 Carlton St

15 Filed APR 16 1929, 19 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 12th 1929.

17 I HEREBY CERTIFY, That I attended deceased from April 7th, 1929, to April 12th, 1929, that I last saw him alive on April 12th, 1929 and that death occurred, on the date stated above, at 11:55 a.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Pneumonia Complications

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Examination

(Signed) J. T. Gunn, M. D.

April 13, 1929 (Address) 522 N. Arlington ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	April 17, 1929
20 UNDERTAKER	ADDRESS 322
Mrs. Katie V. Williams	N. Schroeder St.

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 45087

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-002

E 45087

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 924 W Lexington St. 18-76 Ward)

2-FULL NAME Hazel L Smith

(a) RESIDENCE NO. 924 W. Lex St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 15-1919

7 AGE: Years | Months: 1 | Days | IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town): Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER: Linton Smith

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Phila. Pa.

12 MAIDEN NAME OF MOTHER: Bernice Cooper

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Balto Md

14 Informant: Marcella Cooper
(Address): 924 W. Lexington St

15 Filed ..... 19.... C. HAMPSON JONES, M. D. Registrar

APR 16 1929 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 15 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cap Bronchites

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) 1 yrs. mos. ds.

18 Where was disease contracted If not at place of death? 924 W Lex

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? By Autopsy

Dr. Geo. C. Grady, M. D.

(Address) 1430 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery — DATE OF BURIAL: 4/16 1929

20 UNDERTAKER: Mrs Katie R. Williams — ADDRESS 522

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 45088

E 45088

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Greenmount Apts St. Charles + 34 sts Ward 17-41)

2-FULL NAME Lewis Dill

(a) RESIDENCE NO. Greenmount Apts St. Charles + 34 sts Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret E.

6 DATE OF BIRTH (month, day, and year): Sept. 19, 1859

7 AGE — Years: 69 | Months: 6 | Days: 25 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lumber Merchant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Frederick

(State or country): Md.

PARENTS

10 NAME OF FATHER: Lewis Dill

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Md.

12 MAIDEN NAME OF MOTHER: Ellen Houck

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Md.

14 Informant: Mrs. L. Allan Dill

(Address) 5005 Falls Road

C. HAMPSON JONES, M. D.

Filed ..... 19..... By ..... Registrar

R 187929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/14 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) John J. Morrissey M. D.

(Coroner)

4/15 1929 (Address) 3632 Roland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the state.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cem'y — Date of Burial: Apr. 15 1929

20 UNDERTAKER: John D. Mitchell & Sons — ADDRESS: 19 W. Eutaw Pl.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 45089

E 45089

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 5503 Elsrode Ave (WARD) 27th

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaretha Kunkel

(a) RESIDENCE NO. 5503 Elsrode Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 2 mos. 2 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry C. Kunkel

6 DATE OF BIRTH (month, day and year): Oct 14 1845

7 AGE: Years 83 | Months 6 | Days 2 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: John H. Zink

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Sophia Renner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Miss Sophia T. Kunkel

(Address) 5503 Elsrode Ave

15 Filed APR 16 1929 19 C. HARRISON JONES, M. D. Registrar

BY

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 14 1929

17 I HEREBY CERTIFY, That I attended deceased from March 9, 1929, to April 14, 1929, that I last saw her alive on April 13, 1929, and that death occurred, on the date stated above, at 7 30 m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary): Arterio-Sclerosis Senilis many years (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Morris B. Greed, M. D.

4/16 1929 (Address) Hamilton Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: April 17 1929

20 UNDERTAKER: Fos Joesdens & Son — ADDRESS: 217 S. Pac

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45090

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 45090

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST. 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Robert Weniecki

(a) RESIDENCE NO. 1800 Bank st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Weniecki

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Weniecki

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records

(Address)

15 [illegible] C. HARRISON JONES, M. D.

APR 16 1929 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15, 1929

17

I HEREBY CERTIFY, That I attended deceased from April 12, 1929, to April 15, 1929,

that I last saw him alive on April 15, 1929

and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical and lab.

(Signed) Henry C. Smith M. D.

4-15, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem.	April 18 1929
20 UNDERTAKER	ADDRESS
George A. Weber	705 Lanvale

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45091 — E 45091

CERTIFICATE OF DEATH

1—PLACE OF DEATH — REGISTERED NO. 12557

CITY OF BALTIMORE: (No. 3926 Elm Ave ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James E. Baker

(a) RESIDENCE NO. 3926 Elm Ave ST., 13 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. 7 mos. 23 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nettie F. Baker

6 DATE OF BIRTH (month, day, and year) Aug 2-2-1886

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	42	7	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Checker &

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Western Md Dairy

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER James H. Baker

11 BIRTHPLACE OF FATHER (city or town) Maryland
(State or country)

12 MAIDEN NAME OF MOTHER Lucy E. Reard

13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)

14 Informant Mrs Nettie F. Baker
(Address) 3926 Elm Ave

15 Date received APR 16 1929, 19 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15 1929.

17 I HEREBY CERTIFY, That I attended deceased from Dec 15, 1928, to Apr 15, 1929.

that I last saw him alive on Apr 14, 1929

and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Endo & Myocarditis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Groan Druerd, M. D.

4/15, 1929 (Address) 846 W 36th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	April 17 19 29.
20 UNDERTAKER Horace F. Burase	ADDRESS 363 Halliday

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45092

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

E 45092

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSPITALS ST. 21-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alberta Gross

(a) RESIDENCE NO. 823 W. Oxford ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Negro	Single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) ? 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of Industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) ?

(State or country) Md.

PARENTS

10 NAME OF FATHER John Gross

11 BIRTHPLACE OF FATHER (city or town) ?

(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town) ?

(State or country) Md

14 Informant Records

(Address) BALTIMORE CITY HOSPITALS

APR 16 1928 HAMILTON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-13-29

17

I HEREBY CERTIFY, That I attended deceased from Jan 28, 1929, to 4-13, 1929, that I last saw h.e.r alive on 4-13, 1929 and that death occurred, on the date stated above, at 10:5 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis Chronic

? (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Hypertension

? (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Gross & Microscopic Autopsy

(Signed) Harry W. McCann M. D.

4-14, 1929 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Auburn	4-16 1929
20 UNDERTAKER	ADDRESS
Joseph A Divine	409 Monument St

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Hks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 45093

E 45093

1—PLACE OF DEATH

REGISTERED NO. 90

CITY OF BALTIMORE: (No. 1703 Maryland ST. 15-68 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Helene T. Schmidt

(a) RESIDENCE NO. 1703 Maryland ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. — mos. — ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of William Schmidt

6 DATE OF BIRTH (month, day, and year) June 5. 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	3	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Franz Borchers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Susan Yeldell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Josephine Goodwin

(Address) 1847 N. Mulberry

15 Date APR 16 1929 H. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14-1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 19 . 1928 . to April 14 . 1929 .

that I last saw h alive on April 14 . 1929

and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Endocarditis,

(duration) yrs. 3 mos. 25 ds.

CONTRIBUTORY (Secondary) Endocarditis,

(duration) yrs. 3 mos. 25 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) G. W. Billings, M. D.

. 19 (Address) 224 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL Apr 17 1929

UNDERTAKER H. Rickard & Son

ADDRESS N. Ave

IMPORTANT. See INSTRUCTIONS ON BACK OF CERTIFICATE.

Cor.—10-10-29—A Co.—100 Bks.

E 45094

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

170

REGISTERED NO. E 45094

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 3300 Hilton St.) 15-61 (Ward)

2-FULL NAME Laura M. Dimmling.

(a) RESIDENCE NO. 3300 Hilton St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 43 yrs. 10 mos. 15 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Dimmling

6 DATE OF BIRTH (month, day, and year) May 31 1885

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
43	10	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Geo. Lamb

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Laura Bishop

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Chas Dimmling
(Address) 3300 Hilton St

15 Filed APR 16 1929 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:

Suicide
Pistol wound of Brain
(duration) yrs. Sudden

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Regular.
(Signed) H. F. C. Linck M. D.
19 29 (Address) Coroner.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem.	Apr 18 1929
20 UNDERTAKER Wm Fluckner Sons	ADDRESS North Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45095

CERTIFICATE OF DEATH.

E 45095
REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Women's Hospital

CITY OF BALTIMORE: (No. ..... ST., 1600 WARD)

2-FULL NAME Mary Worley Grant

(a) RESIDENCE NO. 1600 W. Lafayette Ave ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 13 yrs. 7 mos. 0 ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Reid Grant

6 DATE OF BIRTH (month, day, and year) Dec. 19, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	3	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) -
(c) Name of employer -

9 BIRTHPLACE (city or town) (State or country) Memphis, Tennessee

PARENTS
10 NAME OF FATHER John Amos Worley
11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland
12 MAIDEN NAME OF MOTHER Mary Jane Cagle
13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Mary L. Grant
(Address) 1600 W. Lafayette St.

15 Filed ..... 19 ..... HARRISON JONES, M. D. Registrar
Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14 1929

17 I HEREBY CERTIFY, That I attended deceased from February 9, 1929, to April 14, 1929, that I last saw h alive on April 14, 1929, and that death occurred, on the date stated above, at 12:32 p.m.

The CAUSE OF DEATH* was as follows:

Chronic pneumonia

(duration) yrs. 2 mos 5 ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) Earle C. Almon, M. D.

, 19 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	Apr 17 1929
20 UNDERTAKER	ADDRESS
Wm J. Tuckwell Sons	N. Y. Pa

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

APR 16 1929

Spec.—2-29-28—L. F. S.—500 Blks.

Hennegan, ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45096 — CERTIFICATE OF DEATH — 117 — E 45096

1—PLACE OF DEATH

REGISTERED NO. 23-33

CITY OF BALTIMORE: (No. 1s Balto Gen'l (ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elder Hennegan

(a) RESIDENCE NO. 34 Wheeling ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 2 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28	10	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Hennegan

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto., Md

12 MAIDEN NAME OF MOTHER Anna Lowry

13 BIRTHPLACE OF MOTHER (city or town) Balto Md
(State or country)

14 Informant Henry Hennegan
(Address) 34 Wheeling St

15 Date 19 C. HAMILTON JONES, M. D.
Registrar

R 16 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/13/29

17 I HEREBY CERTIFY, That I attended deceased from Apr 1, 1929, to Apr 13, 1929

that I last saw her alive on Apr 13, 1929

and that death occurred, on the date stated above, at 1.25 p.m.

The CAUSE OF DEATH* was as follows:

Toxemia following
acute intestinal
obstruction

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Acute appendicitis

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Yes Date of 4/3/29

Was there an autopsy? Yes

What test confirmed diagnosis? Operative & Clinical

(Signed) William F. Chase, M. D.

4/13, 19 (Address) Jo. Balto. Gen'l Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL April 16 1929

20 UNDERTAKER Margaret J. Flynn

ADDRESS 1422 Light St

Spec.—2-29-28—L. F. S.—500 Bks.

2 E 45097

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 45097

REGISTERED NO.

1—PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ST. 5-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Spellen

(a) RESIDENCE NO. 18 High St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word)

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 41 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) U-Car

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town) (State or country) —

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Recd. (Address) JOHNS HOPKINS HOSPITAL

15 Filed Apr 19 1929 C. HAMPSON JONES, M. D. Registrar

Reg. No. K 8486

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10, 1929.

17 I HEREBY CERTIFY, That I attended deceased from April 9, 1929, to April 10, 1929, that I last saw h/M alive on April 10, 1929 and that death occurred, on the date stated above, at 3 45 A m.

The CAUSE OF DEATH* was as follows:

ac. pneumothorax

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Pneumonia, ? Tbc

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Thoracentesis

(Signed) Chas. Kruger, M. D.

, 19 (Address) John Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: APR 16 1929

20 UNDERTAKER

ADDRESS

Commissioner of Health

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45098

CERTIFICATE OF DEATH. X 46

E 45098

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Howard A Kelly Hospital 1418 Eutaw Place REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ~~Mrs Edward~~ Mary Stutts (Stutts)

(a) RESIDENCE NO. (Usual place of abode) Sanford, N. Carolina ST., WARD

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Stutts

6 DATE OF BIRTH (month, day, and year) 1904

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	25			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) house wife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) unknown probably N. C.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) unknown (State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown (State or country)

14 Informant Myrtle Lewis (sister)

(Address) Sanford, N. C.

15 [illegible]

R 16 1929 C. HAMPSON JONES, M. D. Registrar

Per [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14 1929

17 I HEREBY CERTIFY, That I attended deceased from March 31, 1929, to April 14, 1929, that I last saw her alive on Apr 14, 1929 and that death occurred, on the date stated above, at 10:27 p m.

The CAUSE OF DEATH* was as follows:

Carcinoma of cervix uteri

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of April 1/29

Was there an autopsy? no

What test confirmed diagnosis? biopsy

(Signed) Edmund Kelly M. D.

Apr 14, 1929 (Address) 1418 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sanford North Carolina DATE OF BURIAL April 16 1929

20 UNDERTAKER Chas. G. Black ADDRESS 742 W. North ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45099

CERTIFICATE OF DEATH

166 E 45099

1-PLACE OF DEATH

City of Baltimore: (No. 2209 Brookfield av St., 14-70 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Robt J. Kaplan

(a) RESIDENCE NO 1812 Linden ave St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth 25 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 15 1888

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	40	5		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work attorney
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Russia

PARENTS

10 NAME OF FATHER Harry Kaplan

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Ella

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Leon Kaplan
(Address) 1846 Wabash ave

15 Filed 1929 HARRISON JONES, M. D. Registrar

R 16 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/15 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Jury
(Inquest, autopsy or inquiry)
find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows: Bronchial Pneumonia (Suicide)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jay Morrison, M. D.

4/16 1929 (Address) 2032 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rest Cem	4/16 1929
20 UNDERTAKER	ADDRESS
Jack Lewis	1439 E Balto St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

Hughes

E 45100

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 45100

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSPITALS ST., 19-28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary E Hughes

(a) RESIDENCE NO. 536 Addison Alley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Negro	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Moses Hughes

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) ? 04

(c) Name of employer ?

9 BIRTHPLACE (city or town) ?
(State or country) Md

PARENTS

10 NAME OF FATHER Mike Diggs ?

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) Md.

12 MAIDEN NAME OF MOTHER Laura Young

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) Md

14 Informant Records
(Address)

15 Filed APR 16 1929, 19 HAMPSON JONES M. D. Registrar

0649

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-12-29

17 I HEREBY CERTIFY, That I attended deceased from 11-17, 1926, to 4-12, 1929, that I last saw h[illegible] alive on 4-12, 19 9 and that death occurred, on the date stated above, at 9 [illegible] m.

The CAUSE OF DEATH* was as follows:

Myocarditis Chronic

over (duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis: Hypertension

over (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? [illegible] Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Sign

(Signed) Marion Sill M[illegible], M. D.

4-13, 19 (Address) [illegible] BALTIMORE CITY HOSPITAL

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL April 16 A 1929

20 UNDERTAKER P A Jones — ADDRESS 111 S Gilmor

Important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45101

CERTIFICATE OF DEATH.

90 **E 45101**

1-PLACE OF DEATH Church Home & Infirmary

City of BALTIMORE: (No. Broadway & Fairmount 26-37 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Earl John Henderson

(a) RESIDENCE NO. 3700 Mt. Pleasant Ave 26th Ward

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mable Henderson

6 DATE OF BIRTH (month, day, and year): April 20th 1889

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	39	11	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Butcher

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Plattsmouth Neb.

(State or country)

PARENTS

10 NAME OF FATHER: Samuel Henderson

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Plattsmouth Neb.

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Nebraska

14 Informant: Mabel Henderson Wife

(Address): 3700 Mt. Pleasant Ave

Dated ....., 19 .....

HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 16, 1929 19-9

17

I HEREBY CERTIFY, That I attended deceased from April 12, 1929, to April 16, 1929

that I last saw him alive on April 16, 1929

and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Streptococcus Septicaemia

(?)

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary): Endocarditis

(duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Walter B. Johnson, M. D.

April, 1929 (Address) Church Home & Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Plattsmouth Nebraska — Date of Burial: April 16 1929

20 UNDERTAKER: Lilly & Zeiler Inc. — ADDRESS: 403 S. Wolfe St

R 16 1929

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45102

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31

E 45102

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 120 Amity ST.) (WARD) 18-29

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Samuel Tilly

(a) RESIDENCE NO. 120 Amity ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1903

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
26	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ky. C.

PARENTS

10 NAME OF FATHER Did Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Did Know

12 MAIDEN NAME OF MOTHER Did Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Did Know.

14 Informant Norman Riley

(Address) 120 N. Amity St.

15 Filed 4-16, 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16, 29

17 I HEREBY CERTIFY, That I attended deceased from Feb 2, 1929, to April 16, 1929, that I last saw h— alive on April 15, 1929, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 2 mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) P. H. Bateman, M. D.

4/16 1929 (Address) 1822 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn, Balto. Boundbrook

DATE OF BURIAL 4-19 1929

20 UNDERTAKER Hand Easton

ADDRESS 56 ac.

important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 45103 HEALTH DEPARTMENT—CITY OF BALTIMORE E 45103

CERTIFICATE OF DEATH

1-PLACE OF DEATH Provident Hospital

CITY OF BALTIMORE: (No. 1514 Division St.) (ST. 14 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wesley Mc Cones

(a) RESIDENCE No. 547 North End Harrows St Md WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .. min.
	24			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coal Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) S. C.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Dept on admission
(Address)

15 Filed . 19 HAMPSON JONES, M. D.
Registrar

R 16 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 15 1929

17 I HEREBY CERTIFY, That I attended deceased from Apr 4 . 1929 . to Apr 15 . 1929.

That I last saw h[illegible] alive on Apr 15 . 1929.

and that death occurred, on the date stated above, at 9 45 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Undetermined

Did an operation precede death? No Date of —

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) H. E. Easton M. D.

(Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Jamestown S. C. DATE OF BURIAL 4/16/1929

UNDERTAKER Mrs. Geo. A. Holland ADDRESS 1831 Druid Hill Ave

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45104 HEALTH DEPARTMENT—CITY OF BALTIMORE **E 45104**

CERTIFICATE OF DEATH

92

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 200 N. Payson ST. 20-27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Mc Kenny

(a) RESIDENCE NO. 200 N Payson ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (~~WIFE of~~) Louise Mc Kenny

6 DATE OF BIRTH (month, day, and year) Jan 4 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work CARPENTER 015

(b) General nature of industry, business, or establishment in which employed (or employer) BUILDING

(c) Name of employer OWN BUSINESS

9 BIRTHPLACE (city or town) (State or country) TORONTO CANADA

PARENTS

10 NAME OF FATHER JOHN McKENNY

11 BIRTHPLACE OF FATHER (city or town) (State or country) TORONTO, CANADA

12 MAIDEN NAME OF MOTHER MARY McKENNY

13 BIRTHPLACE OF MOTHER (city or town) (State or country) TORONTO CANADA

14 Informant Trevor McKenny (Address)

15 Filed 4/16 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16th 29

17 I HEREBY CERTIFY, That I attended deceased from 1/20 1929 to 4/16 1929 that I last saw him alive on 4/14 1929 and that death occurred, on the date stated above, at 10:15 a. m.

The CAUSE OF DEATH* was as follows:

(Hemiplegia)
Cerebral Hemorrhage
Sclerosis (duration) 1 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Gangrene of (leg) TK (duration) 0 yrs. 2 mos. 0 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. A. Warren M. D.

4/16 1929 (Address) 6400 Reisterstown Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL 4/18 1929

20 UNDERTAKER Robert Brooks & Son — ADDRESS Calhoun & Hollins St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45105

CERTIFICATE OF DEATH.

E 45105

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3000 McElderry (St.) 7-11 (Ward)

2-FULL NAME Dora King

(a) RESIDENCE. No. 3000 McElderry St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

6a If married, widowed, or divorced, HUSBAND of (or) WIFE of: George L. King

6 DATE OF BIRTH (month, day, and year): July 27-1872

7 AGE: Years 56 Months 8 Days 17 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House-wife

(b) General nature of industry, business, or establishment in which employed (or employer): House-work.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Wm Horner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Rachael Rogers

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Alice King (Address) 3000 McElderry St.

15 Filed: APR 16 1929 C. HAMPSON JONES, M. D., Registrar. Pat

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 14 1929

17 I HEREBY CERTIFY, That I attended deceased from April 3, 1929, to April 14, 1929, that I last saw her alive on April 13, 1929, and that death occurred, on the date stated above, at 9:20 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

CONTRIBUTORY (Secondary) R. Pneumonia (duration) yrs. mos. 12 ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter W. White Jr, M. D.

(Address) 2800 E Pratt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem. — DATE OF BURIAL: April 18 1929

20 UNDERTAKER: Maurice W. E. Dyffel Inc. — ADDRESS: 2121 Eden St

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45106

CERTIFICATE OF DEATH.

E 45106

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: (No. Caton & Wilkens Aves ST., WARD) 25-12

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Adeline Bagnall

(a) RESIDENCE No. Elvaton Q A Co. Md ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Arthur M Bagnall

6 DATE OF BIRTH (month, day, and year) Oct 15 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Charles E Coober

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Louise Coober

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Arthur Bagnall

(Address) Elvaton Q A Co Md

15 Filed R 16 1929 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4—16 1929

17 I HEREBY CERTIFY, That I attended deceased from 4—14 1929 to 4—16 1929,

that I last saw her alive on 4—16 1929,

and that death occurred, on the date stated above, at 2.20 a.m.

The CAUSE OF DEATH* was as follows:

1 Endocarditis, Rheumatic;

2 Myocarditis, mitral stenosis;

3 Cerebral embolism;

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Endocarditis, Myocarditis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Physical Examination Autopsy

(Signed) Nicholas Connelly M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dolfield Cem

DATE OF BURIAL 4 19 1929

20 UNDERTAKER W M Cook

ADDRESS 2174 Ford Av

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45107

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45107.

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 19-29

CITY OF BALTIMORE: (No. 327 S Calhoun ST., WARD 1

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Henry Roberts

(a) RESIDENCE NO. 327 S Calhoun ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E Roberts.

6 DATE OF BIRTH (month, day, and year) Dec 15-1850

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
78	4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired 6 years

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Thomas Roberts

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Charles Wm Roberts

(Address) 327 Calhoun St

15 Filed 4-16 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 - 1929 420 am

17 I HEREBY CERTIFY, That I attended deceased from Feb. 16, 1929, to Apr. 16, 1929, that I last saw h~~im~~ alive on April 15, 1929 and that death occurred, on the date stated above, at 4:20 a m.

The CAUSE OF DEATH* was as follows:

Arterio sclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Wm T Bispham, M. D.

19 (Address) 1324 N. Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	April 18 1929
20 UNDERTAKER	ADDRESS
William Cook	1217 St Paul St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45108

CERTIFICATE OF DEATH.

E 45108

1-PLACE OF DEATH

REGISTERED NO. 101-61

CITY OF BALTIMORE: (No. 3206 Ravenwood Ave ST.: 8-40 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harry W. Keller

(a) RESIDENCE. No. 3206 Ravenwood Ave. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced
(or) WIFE of Mary Keller

6 DATE OF BIRTH (month, day, and year) Feb 19-1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	1	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Advertising Agent

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER William Keller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington

12 MAIDEN NAME OF MOTHER Amanda Hemlene

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington

14 Informant Mrs Mary Keller
(Address) 3206 Ravenwood

15 Filed 19 J. HAMPSON JONES, M. D., Registrar

By

R 161929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15 1929

17 I HEREBY CERTIFY, That I attended deceased from April 7 1929, to April 15 1929, that I last saw him alive on April 15 1929, and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John T Avery, M. D.

(Address) 1603 Brookdowney

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oakland Cemetery	4/18 1929
20 UNDERTAKER	ADDRESS
Wm Cook	1417 St Paul

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 45109

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 45109

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 529 Richwood Ave ST., 17-48 WARD

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah E. Ching

(a) RESIDENCE No. 529 Richwood Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of or) WIFE of Henry Ching

6 DATE OF BIRTH (month, day, and year) July 14, 1877

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
51	9	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Henry Fowler

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Ely

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Md

14 Informant Howard Bailey

(Address) 205 E. Lake Ave

R Apr 16 1929, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 15 19 29

17

I HEREBY CERTIFY, That I attended deceased from Dec 10, 1928, to April 15, 1929.

that I last saw h alive on April 14, 1929

and that death occurred, on the date stated above, at 10 30 A. m.

The CAUSE OF DEATH* was as follows:

Gen Carcinomata

(duration) 4 yrs. 5 mos ds.

CONTRIBUTORY (Secondary) Carcinoma of Uterus

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Path. + Clinical

(Signed) H C Hess, M. D.

4-16, 1929 (Address) 5600 York Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge

DATE OF BURIAL 4 17 19 29

UNDERTAKER .....

ADDRESS 217 N. Howard

TION is very important See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45110 **E 45110**

CERTIFICATE OF DEATH.

+107-003

REGISTERED NO.

1-PLACE OF DEATH Church Home & Infirmary

City of BALTIMORE: (Broadway or Hospital) St. 19 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Ford

(a) RESIDENCE NO. 406 Hanover St. Fredericksburg Va St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Belle H. Ford.

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE: Years 63. Months Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Unknown

PARENTS

10 NAME OF FATHER Ford

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Unknown

14 Informant Mrs. Elizabeth Ford

(Address) 309 E. 31st St.

15 APR 16 1929 19 THOMPSON-WALSH, INC. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/16 1929

17 I HEREBY CERTIFY, That I attended deceased from 4/9 1929, to 4/16, 1929, that I last saw him alive on 4/6, 1929, and that death occurred, on the date stated above, at 7:40 m.

The CAUSE OF DEATH* was as follows:

Lung Abscess

(duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Acute Pulmonary Hemorrhage

(duration) yrs. mos. 10 min

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) Chas B. Wallace M. D.

, 19 (Address) Church Home & Infir. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Fredericksburg Va Date of Burial 4/16 1929

20 UNDERTAKER: John O Mitchell Son ADDRESS 1901 Eutaw

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45111

CERTIFICATE OF DEATH.

E 45111

1-PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Age ment + rooms) house ST., 14 (Old 20) WARD

2-FULL NAME Mary Statom

(a) RESIDENCE No. 1622 Druid Hill ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	colored	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) [illegible] 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cambridge Md

PARENTS

10 NAME OF FATHER ? [illegible]

11 BIRTHPLACE OF FATHER (city or town) [illegible]
(State or country)

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

14 Informant Mrs Taylor
(Address) 1622 Druid Hill Ave

15 Filed 1929 H. A. Pol JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15 1929

17 I HEREBY CERTIFY, That I attended deceased from March 2, 1929, to April 15, 1929, that I last saw h[illegible] alive on April 10, 1929 and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edw. J. Shadley, M. D.

4/16, 1929 (Address) 1233 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL Apr 17 1929

20 UNDERTAKER John H. Jenkins

ADDRESS 1027 Druid Hill Ave

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45112 — CERTIFICATE OF DEATH — 45 — E 45112

1—PLACE OF DEATH 3710 Canmer LANE

REGISTERED NO. 13-57

CITY OF BALTIMORE: (No. 3710 Canmer Lane ST. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ruth L. Roberts

(a) RESIDENCE NO. 3710 Canmer Lane ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5yr mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James H Roberts

6 DATE OF BIRTH (month, day, and year) Aug 26 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	74	7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Grace Smith

(Address) 3710 Canmer Lane

15 Filed APR 17 1929 HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-16-29

17 I HEREBY CERTIFY, That I attended deceased from March 8, 1929, to April 15, 1929, that I last saw h alive on April 15, 1929, and that death occurred, on the date stated above, at 830 A. m.

The CAUSE OF DEATH* was as follows:

Cancer of Transverse Colon.

(duration) yrs. mos. 37 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) G. J. Davies, M. D.

4-16 1929 (Address) 800 W 33rd Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	Apl 18 1929
20 UNDERTAKER Cohenour & Son	ADDRESS 347 Edmondson

Spec.—2-29-28—L. F. S.—500 Bks.

E 45113

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45113

CERTIFICATE OF DEATH

24-001

REGISTERED NO. 13257

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3034 (St.) Keswick (Ward) 13

2—FULL NAME Joseph H Middleton

(a) RESIDENCE NO. 3034 (St.) Keswick Rd (Ward)

(Usual place of abode)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of: Maggie Middleton

6 DATE OF BIRTH (month, day, and year): Sept 4 1870

7 AGE: 58 Years | Months 7 | Days 11 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer): 015

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): ?

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ?

14 Informant: Maggie Middleton (Address) 3034 Keswick Rd

15 Filed APR 7 1929 THOMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 15 1929

17 I HEREBY CERTIFY, That I attended deceased from Apr 1 st, 1929, to Apr 15, 1929;

that I last saw him alive on Apr 15 1929

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jordan Driver M. D.

4/16, 1929 (Address) 846 W 36th St Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Hunt Co

DATE OF BURIAL: April 17 29

20 UNDERTAKER: Ehrnowetz & Son

ADDRESS: 567 Eastern Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

CERTIFICATE OF DEATH

E 45114

E 45114

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1820 Aliceanna st ST. 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edward. ostrowski

(a) RESIDENCE NO. 1820 aliceanna st ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	Infant.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June. 5 / 1928

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	10	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant-

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Stanislaw ostrowski

11 BIRTHPLACE OF FATHER (city or town) Poland.
(State or country)

12 MAIDEN NAME OF MOTHER Maryanna. olesczuk

13 BIRTHPLACE OF MOTHER (city or town) poland.
(State or country)

14 Informant Stanislaw ostrowski
(Address) 1820 aliceanna st.

15 Filed APR 17 1929, 19 Registrar C. HAMPSON SMITH, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 29

17 I HEREBY CERTIFY, That I attended deceased from April 16 29, to April 16, 1929
that I last saw her alive on April 16, 1929
and that death occurred, on the date stated above, at 2150 m.

The CAUSE OF DEATH* was as follows:

1 Broncho Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Death

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J. Ryan M. D.

M. D., (Address) 801 W Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary cemetry — DATE OF BURIAL April 18 1929.

20 UNDERTAKER George A. Weber — ADDRESS 705 S. ann st.

Important.—See instructions on back of Certificate.

Spec.—2-29-28—L. F. S.—500 Blks. Jos. Morales De los Rios y Otero

E 23489
E 45115

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 90 ✓ E 45115

1—PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 19 WARD) REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jose Morales De los Rios y Otero

(a) RESIDENCE NO. 3625 - 16st N.W. Wash. DC ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. 1 mos. ..... ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W	married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Harrison

6 DATE OF BIRTH (month, day, and year) .....

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) retired

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Cuba

PARENTS

10 NAME OF FATHER Jose Morales de los Rios y Morphy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Spain

12 MAIDEN NAME OF MOTHER Barbara Otero y Urdaneta

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Venezuela (?)

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 17 1929 C. H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 - 1929

17 I HEREBY CERTIFY, That I attended deceased from March 17, 1929, to April 16, 1929, that I last saw h[illegible] alive on April 16, 1929 and that death occurred, on the date stated above, at 2.45 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Myocardial Insufficiency

(duration) ? yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? general & laboratory

(Signed) C. H. Hooper Jones, M. D.

April 16 1929 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Havanna Cuba	April 17 - 1929
20 UNDERTAKER	ADDRESS
John O. Mitchell & Sons, 1900	Eutaw Place

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45116

CERTIFICATE OF DEATH

+45

E 45116

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hosp. ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mr. Samuel Barnett

(a) RESIDENCE NO. 1376 (Usual place of abode) ST., Bartlett WARD N.Y.

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 28 ds. How long in U. S., if foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of Mrs Hannah L. Barnett. (or) WIFE of Maiden name (Hannah Kaplowitz)

6 DATE OF BIRTH (month, day, and year) Jan 15 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
55	55	3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Banker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Gurson Barnett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Mariam Hecker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jos. E. Siegel

(Address) 16 E 42nd St Dr. Y

15 Filed APR 17 1929 THOMPSON JOINES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 17, 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb 20, 1929, to Apr. 17, 1929, that I last saw him alive on Apr 17, 1929 and that death occurred, on the date stated above, at 6.45 A m.

The CAUSE OF DEATH* was as follows:

Carcinomatosis Abdominalis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis Chronic

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. J. Geraghty, M. D.

4/17, 1929 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New York City N.Y.

DATE OF BURIAL 4/20 1929

20 UNDERTAKER Jack Lewis

ADDRESS 1484 Eutaw St

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45117
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

31 E 45117
REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 848 Whitmore A ve. ST. 16-68 WARD)

2-FULL NAME Alleulah Rollins

(a) RESIDENCE NO. 848 Whitmore A ve ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 15th 1869

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
60	1	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work A T HOME
(b) General nature of industry, business, or establishment in which employed (or employer) 0
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Va.

PARENTS
10 NAME OF FATHER Washington Rollins
11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)
12 MAIDEN NAME OF MOTHER Frances Mardes
13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14
Informant Ophelia Rollins
(Address) 848 Whitmore Ave.

15 Filed APR 7 1929 H. JACKSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 6 1929

17
I HEREBY CERTIFY, That I attended deceased from Jan 1, 1928, to April 14, 1929, that I last saw her alive on April 14, 1929, and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis
(duration) Unknown yrs. mos ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Signs & Symptoms
(Signed) Chas A Cof M. D.
4/11, 1929 (Address) 547 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL Apr. 18 1929
20 UNDERTAKER Chas. E. Franck — ADDRESS 802 Madison Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupa-
TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45118 HEALTH DEPARTMENT—CITY OF BALTIMORE E 45118

CERTIFICATE OF DEATH

113

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. University Hosp. ST. 21-31 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emma Fisher

(a) RESIDENCE NO. 731 W. Barre ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 6 mos 20 ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 27/1928

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Henry J Fisher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Maud Kerns

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Norfolk Va

14 Informant Henry J Fisher
(Address) 679 W Barre st

15 Filed ..., 19 C. HAMPSON JONES, M. D.
R 17932 By ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/16/29

17 I HEREBY CERTIFY, That I attended deceased from 3/15/, 1929, to 4/16/, 1929, that I last saw her alive on 4/16/, 1929 and that death occurred, on the date stated above, at 4.35 P. m.

The CAUSE OF DEATH* was as follows:

Deep humeral abscess

Septicaemia

Infectious diarrhoea (proteolytic)

(duration) yrs. mos. da.

CONTRIBUTORY (Secondary) Malnutrition & dehydration

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry Steinberg, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	Apl 18 1929
UNDERTAKER John F Denny	ADDRESS 715 Light St

Spec.—1-12-23—M&T—500 Bks.

E 45119 HEALTH DEPARTMENT—CITY OF BALTIMORE E 45119

CERTIFICATE OF DEATH.

47

REGISTERED NO. 7756

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3810 Fenelon Lane ST. WARD)

2-FULL NAME Mary Virginia Bamberger

(a) RESIDENCE NO. 3810 Fenelon Lane ST. Rd WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jas. E. Bamberger

6 DATE OF BIRTH (month, day, and year) May 12 1839.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	89	11	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Jas. Howard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Mary Gold

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mrs. J. J. Rosendale

(Address) 3810 Fenelon Lane

15 Filed APR 17 1929 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/16 1929

17 I HEREBY CERTIFY, That I attended deceased from May, 1926, to 4/16, 1929, that I last saw h[illegible] alive on 4/15, 1929, and that death occurred, on the date stated above, at 8.25 A. m.

The CAUSE OF DEATH* was as follows:

Old age

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cancer of breast

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) J. Edw. Lynch, M. D.

4/17, 1929 (Address) 310 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL April 19 1929

20 UNDERTAKER John F. Denny — ADDRESS 310 Light St

TION is very important See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 45120

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 45120

167-01

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Johns Hopkins Hospital St., 3-4 Ward)

2-FULL NAME Hubert Reynolds

(a) RESIDENCE NO. 406 S. Caroline St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 23/1902

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	26	7	23 22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) N.C.

PARENTS

10 NAME OF FATHER Robert Reynolds

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) N.C.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Unknown

14 Informant Cora L. Hall
(Address) 406 S. Caroline St

15 Filed ....., 19..... C. HAMPSON JONES, M. D., Registrar
Per .....

R 171929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 15/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Illuminating Gas Poisoning
probable suicide

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) J. S. H. Cotton, M. D.

4/16/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cofield N.C. — DATE OF BURIAL: April 17, 1929

20 UNDERTAKER Edward Boyan — ADDRESS 1691 Orleans St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45121

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

74-001

E 45121

REGISTERED NO.

CITY OF BALTIMORE: (No.) 414 Park ST. 4[illegible] (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Valentine Peschek (Pesch)

(a) RESIDENCE NO. 414 Park ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? 28 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE: Years 54 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Bohemia

PARENTS

10 NAME OF FATHER: Frank Peschek

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bohemia

12 MAIDEN NAME OF MOTHER: Mary Slaby

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bohemia

14 Informant: Frances Peschek

(Address) 414 N Port St

15 Date received APR 17 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 15 1929

17 I HEREBY CERTIFY, That I attended deceased from 4/14, 1929, to 4/15, 1929, that I last saw her alive on 4/15, 1929, and that death occurred, on the date stated above, at 12.20 m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm D Carey M. D.

, 19 (Address) Carey & Southern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: April 18 1929

20 UNDERTAKER: Frank Brockton — ADDRESS: 1806 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT statement of OCCUPA-TION is very important See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 45122

HEALTH DEPARTMENT—CITY OF BALTIMORE

Zucek

CERTIFICATE OF DEATH.

74-001

E 45122

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 818 N. Belnord Ave St. 7-12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Zucek

(a) RESIDENCE NO. 818 N. Belnord Ave St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Barbara Zucek

6 DATE OF BIRTH (month, day, and year) Aug 24, 1856

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	72	7	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Bohemia

PARENTS

10 NAME OF FATHER Charles Zucek

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Bohemia

12 MAIDEN NAME OF MOTHER Barbara Secura

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Bohemia

14 Informant Barbara Zucek

(Address) 818 N. Belnord Ave

15 Filed ..... 19 ..... Registrar

PR 171923 C. HAYDON JONES, M. D. Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15 1929

17 I HEREBY CERTIFY, That I attended deceased from March 27 1929, to April 15, 1929, that I last saw h— alive on April 15, 1929, and that death occurred, on the date stated above, at 3.30 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

CONTRIBUTORY (duration) ..... yrs. ..... mos. 19 ds.
(Secondary) Cardiac Pericarditis

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William G. Caner M. D.

(Address) 20 W. Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Date of Burial April 18 1929

20 UNDERTAKER Frank Woodson ADDRESS 1406 Eutaw Pl

OF DEATH in plain terms, so that it may be properly classified. Exact statement, of OCCUPATION very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 45123

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

89

E 45123

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Walbrook Apt. St. 15-67 (Ward)

2-FULL NAME Fred Shaw

(a) RESIDENCE NO. Walbrook Apt St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lillie Shaw

6 DATE OF BIRTH (month, day, and year): Nov 9th 1865

7 AGE: Years 63 | Months 5 | Days 6 | IF LESS than 1 day ..hrs. or ..min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Stationary Engineer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town): England
(State or country)

PARENTS

10 NAME OF FATHER: Thos. Shaw

11 BIRTHPLACE OF FATHER (city or town): England
(State or country)

12 MAIDEN NAME OF MOTHER: Mary J. Pearson

13 BIRTHPLACE OF MOTHER (city or town): England
(State or country)

14 Informant: Lady Shaw Widow
(Address) Walbrook Apt

15 Filed ....., 19.. C. HAMPSON JONES, M. D., Registrar
per

R 171929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): Aug 12th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to his death (autopsy or inquiry) on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. Sudden

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) A. Gelbach, M. D.
(Address) Aug 15th 1929 Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery

DATE OF BURIAL: Aug 18 1929

20 UNDERTAKER: Wm Fickus Sons

ADDRESS: North & Pa

Spec.—2-29-28—L. F. S.—500 Bks.

E 45124 HEALTH DEPARTMENT—CITY OF BALTIMORE **E 45124**

CERTIFICATE OF DEATH

129

1—PLACE OF DEATH

REGISTERED NO. 4-37

CITY OF BALTIMORE: (No. 400 S. Eaton st. ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Howard L. Forsythe

(a) RESIDENCE NO. 400 S Eaton st ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lf yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of "

6 DATE OF BIRTH (month, day, and year) Oct. 13-1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	6	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Saloon Keper

(b) General nature of industry, business, of establishment in which employed (or employer) himself

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Co.

PARENTS

10 NAME OF FATHER Harry C. Forsythe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Katie V. Steil

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Frank Hoen Forsythe

(Address) 116 Leeds Ave (Arbutus)

15 Filed APR 17 1929 HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15-1929

17 I HEREBY CERTIFY, That I attended deceased from April 13 19 29 to April 15 19 29

that I last saw h[illegible] alive on April 13-29

and that death occurred, on the date stated above, at 4 20 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. W Herrman M. D.

April 16 19 (Address) 2913 E Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem.

DATE OF BURIAL April 18 1929

*20 UNDERTAKER Philip Herwig

ADDRESS 2016 Orleans st

Spec.—2-29-28—L. F. S.—500 Bks.

E 45125 HEALTH DEPARTMENT—CITY OF BALTIMORE 101-001 E 45125

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Saint Joseph's Hospital ST. 712 WARD)

2—FULL NAME Joseph Robb

(a) RESIDENCE NO. 1218 N. Chester ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Married Julia A Robb

6 DATE OF BIRTH (month, day, and year): Jan 4-1881

7 AGE: Years 48 | Months 3 | Days 12 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Silver Smith

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto.

PARENTS

10 NAME OF FATHER: Winslow Robb

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ger.

12 MAIDEN NAME OF MOTHER: Catherine

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ger.

14 Informant: Julia A. Robb. (Address) 1218 N. Chester st

15 Filed APR 17 1929 By C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/16/29

17 I HEREBY CERTIFY, That I attended deceased from 4/5, 1929, to 4/16, 1929, that I last saw him alive on 4/16, 1929 and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Septicemia

(duration) yrs. 1 mos. 6 ds.

CONTRIBUTORY (Secondary): Dyspepsia

(duration) yrs. mos. 14 ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. Z. Zimmerman, M. D.

, 19 (Address) St Josephs Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: Oak Lawn Cem

DATE OF BURIAL: April 19 1929

20 UNDERTAKER: Philip Hering

ADDRESS 2016 Orleans st

Spec.—2-29-28—L. F. S.—500 Bks.

E 45126 HEALTH DEPARTMENT—CITY OF BALTIMORE **E 45126**

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2523 W. Fairmount Ave. WARD)

2—FULL NAME Ernst L. Konig

(a) RESIDENCE NO. 2523 W. Fairmount Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if foreign birth 55 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Estella Konig

6 DATE OF BIRTH (month, day, and year) June 7, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	10	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Armour Co.

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Mrs. Arthur Lang

(Address) 2523 W. Fairmount Ave

Filed APR 17 1929 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 16/29

17 I HEREBY CERTIFY, That I attended deceased from May 28, 1928, to Apr. 16, 1929, that I last saw him alive on Apr. 16, 1929 and that death occurred, on the date stated above, at 7.05 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 8 mos. 19 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Jacob Fisher, M. D.

4/16, 1929 (Address) 1823 N. Wash. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem DATE OF BURIAL April 20 1929

20 UNDERTAKER Philip Herwig ADDRESS 2016 Orleans St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45127

60-002

CERTIFICATE OF DEATH

E 45127

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH St Joseph's Inf 27-46

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

2—FULL NAME John J Brookman

(a) RESIDENCE NO. 5802 Winner Ave. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katie Brookman

6 DATE OF BIRTH (month, day, and year) May 13, 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	11	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bricklayer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Cumberland (State or country) Maryland

PARENTS

10 NAME OF FATHER John J. Brookman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Katie Brookman

(Address) 5802 Winner Ave.

15 C. HAMPSON JR. M. D.

Registrar

R 171929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 23, 19 29, to April 16, 19 29.

that I last saw h.... alive on April 16, 19 29,

and that death occurred, on the date stated above, at 7 15 P.m.

The CAUSE OF DEATH* was as follows:

Pyelonephritis

and

(duration) 25 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

4/16, 1929 (Address) St Joseph's Inf

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cumberland, Maryland

DATE OF BURIAL Apr. 19, 1929

20 UNDERTAKER [illegible]

ADDRESS 1003 West Baltimore St.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45128

CERTIFICATE OF DEATH

90 E 45128

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 217 N Calhoun ST., 19-76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Minnie L. Graf

(a) RESIDENCE NO. 217 N Calhoun ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 86 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Wht	Wid

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Valentine Graf

6 DATE OF BIRTH (month, day, and year) July 17 42

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	86	8	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Geo J Meech

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Henry Apl 16 Md

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant E. L. McGee

(Address) 217 N Calton

Received APR 17 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15 29

17

I HEREBY CERTIFY, That I attended deceased from Jan 16, 1929, to April 15, 1929,

that I last saw h alive on April 10, 1929

and that death occurred, on the date stated above, at 1 P M m.

The CAUSE OF DEATH* was as follows:

Organic Disease of Heart

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of No

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F H Woodward, M. D.

Apl 16 1929 (Address) 939 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Bur

DATE OF BURIAL April 18 1929

UNDERTAKER D. W. McCourtson

ADDRESS 223 S W North

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45129 E 45129

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5213 Linden Hgts Ave (STREET) 2-55 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorothy Agnes Swain

(a) RESIDENCE NO. 5213 Linden Hgts Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 21 28

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		10	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Alfred N Swain

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Eugenia Buttner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Alfred N Swain

(Address) 5213 Linden Hgts Ave

15 Filed APR 17 1929 19 H. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17 1929

17

I HEREBY CERTIFY, That I attended deceased from April 12, 1929, to April 17, 1929, that I last saw her alive on April 17, 1929, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchial Pneumonia complicated with Colitis and Hernia.

(duration) yrs mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Symptoms

(Signed) G. L. Bucklage, M. D.

19 (Address) 3337 Belair Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL April 19 1929

20 UNDERTAKER W M Boettcher

ADDRESS 2238 N Mon Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXPLANATION of obscure

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Hks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

45130

CERTIFICATE OF DEATH

129 ✓

1—PLACE OF DEATH

REGISTERED NO. E 45130

CITY OF BALTIMORE: (No. 37 S Potomac ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Pearl E. Ilgenfritz.

(a) RESIDENCE NO. 37 S Potomac ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of John C Ilgenfritz

6 DATE OF BIRTH (month, day, and year) June 15 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER James M Boston

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Susie E Collins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant John C Ilgenfritz

(Address) 37 S Potomac

15 APR 17 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15-1929

17 I HEREBY CERTIFY, That I attended deceased from Feb 8, 1929, to April 14, 1929, that I last saw h[illegible] alive on April 14, 1929 and that death occurred, on the date stated above, at 5-25 a m.

The CAUSE OF DEATH* was as follows:

Oedema of Lungs, Uraemia.
Chronic Interstitial Nephritis
Hypertension (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Albert L Webster, M. D.

19 (Address) 6409 Belair Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem

DATE OF BURIAL Apl 18 1929

20 UNDERTAKER John Ullrich

ADDRESS 2008 Eutaw

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45131 + 100 .081 E 45131

CERTIFICATE OF DEATH

E 45131

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Joseph's Hospital ST., 9-17 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry Hoffmeister

(a) RESIDENCE NO. Sterrmers Run, Ind. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A. Hoffmeister

6 DATE OF BIRTH (month, day, and year) June 6th 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ..a..min.
	51	10	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steel Worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Bethlehem Steel Co

9 BIRTHPLACE (city or town) Balto. Co.

(State or country) Maryland

PARENTS

10 NAME OF FATHER Albert E. Hoffmeister

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret E. Stohr

13 BIRTHPLACE OF MOTHER (city or town) Balto. Co.

(State or country) Maryland

14 Informant Mary A. Hoffmeister

(Address) Sterrmers Run Ind.

15 Filed APR 17 1929 HAMPSON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/16/29

17

I HEREBY CERTIFY, That I attended deceased from 4/12/29, 19..., to 4/16/29, 19...,

that I last saw him alive on 4/16/29, 19...

and that death occurred, on the date stated above, at 2:30 P. m.

The CAUSE OF DEATH* was as follows:

left inguinal hernia

..... (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) broncho-pneumonia

..... (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 4/13/29

Was there an autopsy? No

What test confirmed diagnosis? Clinical Course

(Signed) A B Hendrix, M. D.

, 19 29 (Address) Druid Heights

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	April 19 1929

20 UNDERTAKER Frederick Lassahn ADDRESS Catonsville Md

Cor.—12-9-25—A Co.—200 Bks.

E 45132

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 45132

REGISTERED NO. 185

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1001 St. Paul St. St., 11-15 Ward)

2-FULL NAME Harriet Louise Ingham

(a) RESIDENCE NO. 1001 St. Paul St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 28, 1898

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	30	3	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Kansas

PARENTS

10 NAME OF FATHER Sidney Ingham

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Nebraska

12 MAIDEN NAME OF MOTHER Angie Henderson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Mio.

14 Informant Charles W. Ingham

(Address) Oklahoma City Oklahoma

17 C. HAMPSON JONES, M. D.

Registrar

R 17 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 15 29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said Inquest

(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probable internal injuries caused by a accidental fall from window at other address.

Prob. fract. of skull &c.

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Undetermined

(duration) yrs. mos. ds.

Apr. 17 (Signed) W. J. Chew M. D.

(Coroner)

, 19 29 (Address) 1639 Parrish

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oklahoma City Okl. Date of Burial 4/17 1929

20 UNDERTAKER Chas F. Evans & Son ADDRESS 118 W. Main Royal Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45133

CERTIFICATE OF DEATH

38

E 45133

1—PLACE OF DEATH

REGISTERED NO. 15-63

CITY OF BALTIMORE: (No. So Balto Gen Hosp (Street) (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Clarence F. Colbert

(a) RESIDENCE NO. 3820 Kate ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annette B Colbert

6 DATE OF BIRTH (month, day, and year) Dec 28/1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
49	50	3	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 66

(b) General nature of industry, business, or establishment in which employed (or employer) Canning.

(c) Name of employer Berlin Chapman Co Berlin Md

9 BIRTHPLACE (city or town) (State or country) Mantua N.J.

PARENTS

10 NAME OF FATHER John Colbert

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Jersey

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Annette B Colbert

(Address) 3820 Kate Ave

15 [illegible] 19 [illegible] C. HAMPSON JONES, M. D. Registrar

R 17 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/16/29

17 I HEREBY CERTIFY, That I attended deceased from 4/15, 1929, to 4/16, 1929

that I last saw him alive on 4/16, 1929

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism.
Cerebro Spinal Lues

CONTRIBUTORY (Secondary) (duration) Unknown yrs. mos. ds.

Pulmonary Edema

(duration) yrs. mos. 6 Days

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Seton Wascoe M. D.

4/16, 1929 (Address) So Balto Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	April 19 1929

20 UNDERTAKER Harry A. Simmons ADDRESS 4204 Fredgewood Ave

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45134

CERTIFICATE OF DEATH.

166 **E 45134**

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Pronounced Dead at

City of BALTIMORE: (No. Balto City Hospital 1-1 Ward)

2-FULL NAME Wm J Hartnett Jr

(a) RESIDENCE NO. 807 S Ellwood St. ____ Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. 6 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Mal	Wht	Sngl

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs

6 DATE OF BIRTH (month, day, and year) Oct 12 1908

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	20	6	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Crown Cork & Seal Co.

9 BIRTHPLACE (city or town) Balto City

(State or country)

PARENTS

10 NAME OF FATHER Wm Hartnett

11 BIRTHPLACE OF FATHER (city or town) Balto

(State or country) Md

12 MAIDEN NAME OF MOTHER M. Emma Lee

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Md

14 Informant Mrs Emma Hartnett

(Address) 807 S Ellwood

15 1 7 1929 C. HAMPSON JONES, M. D. Registrar

Ref

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4 16 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Pneumonia

Duration Wks

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) James H Kenton M. D.

(Coroner)

4 17 1929 (Address) 700 E Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Abingdon M. E. Cem. Date of Burial Apr. 19 1929

20 UNDERTAKER Wm C Black ADDRESS 927 N Broadway

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45135

CERTIFICATE OF DEATH

E 45135

1-PLACE OF DEATH Jenkins Memorial Hospital REGISTERED NO.

City of BALTIMORE: (No. 2000 Eaton Ave. St. 9-44 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie Richardson

(a) RESIDENCE NO. 1132 Gorsuch Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 15/1860

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	68	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Denton Maryland

(State or country)

PARENTS

10 NAME OF FATHER B. Richardson

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Denton md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Denton md

14 Informant Jenkins Memorial Hospital

(Address) Eaton Ave

Filed C. HAMPSON JONES, M. D. Registrar

By

R 171929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15-1929 19 29

17 I HEREBY CERTIFY, That I attended deceased from April 3 1929 to April 15 1929

that I last saw h alive on April 14 1929

and that death occurred, on the date stated above, at 1.55 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Carcinoma L. Breast (left)

(duration) 1 yrs. 3 mos. da.

CONTRIBUTORY (Secondary) General Carcinomatosis

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Clinical & Physical

(Signed) Graduate Nurse M. D.

, 19 (Address) Lying In Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

New Cathedral Cemetery April 15 19 29

20 UNDERTAKER George J. Rice ADDRESS 1735 Harford Av

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45136

CERTIFICATE OF DEATH

E 45136

1—PLACE OF DEATH

REGISTERED NO. 13-57

CITY OF BALTIMORE: (No. 800 Wellington ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Richard W. Gross

(a) RESIDENCE NO. 800 Wellington ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Gross

6 DATE OF BIRTH (month, day, and year) April 26, 1857

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
71	11	22 20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber's Helper

(b) General nature of industry, business, or establishment(in which employed (or employer) 259

(c) Name of employer Harry S. Gross

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry S. Gross

11 BIRTHPLACE OF FATHER (city or town) Balto Co. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Martha Hagerty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Harry S. Gross
(Address) 800 Wellington St.

15 R 171929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 16-29.

17 I HEREBY CERTIFY, That I attended deceased from Apr 1 '29, to Apr 16 '29, that I last saw h alive on Apr 16 '29, and that death occurred, on the date stated above, at 4 20 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of face Floor

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jerman Jenkins, M. D.

4/17, 1929 (Address) 846 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery — DATE OF BURIAL April 19, 1929

20 UNDERTAKER E. Leroy Stiffler — ADDRESS 125 E. North ave.

Spec.—2-29-28—L. F. S.—500 Bks.

Dr Katzenberger 1729 N Lombard

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45137 — 90 — E 45137

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 14-28

CITY OF BALTIMORE: (No.) 1802 Wilhelm ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William F. Schaefer

(a) RESIDENCE NO. 1802 Wilhelm ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah E Schaefer

6 DATE OF BIRTH (month, day, and year) Oct 5, 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54	7	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sheet Metal Worker

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Herman Schaefer

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Isabella Smith

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Mrs Sarah Schaefer
(Address) 1802 Wilhelm St

15 APR 17 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 16. 1929

17 I HEREBY CERTIFY, That I attended deceased from Apr 13, 1929, to Apr 16, 1929, that I last saw h— alive on Apr 15, 1929 and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows: Chronic Cardiac Dilatation

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Nephritis (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) James T. Katzenberger M. D.

4/17, 1929 (Address) 1729 N Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem — DATE OF BURIAL 4/19/1929

20 UNDERTAKER J. H. Cook — ADDRESS 217 N Eutaw St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45138 74 001 E 45138

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) St Josephs Hosp ST. (WARD) 7-44

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry Niebuhr

(a) RESIDENCE NO. 5604 Govane Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Augusta Niebuhr

6 DATE OF BIRTH (month, day, and year) Nov. 2. 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Fiona White

(Address) 5604 Govane Ave

15 Filed, 19 C. HAMPSON JONES, M. D.

Registrar

Par ACA

17 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-17-29

17

I HEREBY CERTIFY, That I attended deceased from Apr. 15, 1929, to Apr. 17, 1929,

that I last saw him alive on Apr. 16, 1929

and that death occurred, on the date stated above, at 7 35 a m.

The CAUSE OF DEATH* was as follows:

Atypic Pulmonic Tby pertussion

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. E. Upton, M. D.

4-17, 1929 (Address) St Josephs Hosp

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	4 20 1929
20 UNDERTAKER	ADDRESS
Wm. Cook	2, N Eutaw St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45139

CERTIFICATE OF DEATH

E 45139

1—PLACE OF DEATH

REGISTERED NO. 27-53

CITY OF BALTIMORE: (No. Roland and Belevedere ST. Aves WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anne VAn Arsdale Tongue

(a) RESIDENCE NO. Roland and Belevedere Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas T. Tongue

6 DATE OF BIRTH (month, day, and year) August 14, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	8	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer At Home

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Andrew M. Van Arsdale

11 BIRTHPLACE OF FATHER (city or town) Martinsburg (State or country) West Virginia

12 MAIDEN NAME OF MOTHER Mary Wolfe

13 BIRTHPLACE OF MOTHER (city or town) Martinsburg (State or country) West Virginia

14 Informant Thomas T. Tongue

(Address) Roland and Belevedere Aves

15 Filed 8 1929, 19 L. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 25th, 19 29, to April 16th, 19 29, that I last saw her alive on April 16th, 19 29 and that death occurred, on the date stated above, at 6.20 P m.

The CAUSE OF DEATH* was as follows:

Embolism
(Cerebral)

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? - - - - - -

Did an operation precede death? No Date of - - - - - -

Was there an autopsy? No

What test confirmed diagnosis? - - - - - -

(Signed) Thomas L. Sheary, M. D.

, 17, 19 29 (Address) 905 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL April 18, 1929

20 UNDERTAKER Joseph Cook

ADDRESS 1003 West Baltimore St

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45140

CERTIFICATE OF DEATH

E 45140

1—PLACE OF DEATH

REGISTERED NO. 29

CITY OF BALTIMORE: (No. 1006 W. Lombard ST. 6 WARD) 18-29

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William J. Lee

(a) RESIDENCE NO. 1006 W. Lombard St. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Lee

6 DATE OF BIRTH (month, day, and year) August 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	62	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Samuel James Lee

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Amelia Jane Hardy

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mrs. Florence Lee
(Address) 1017 W. Lombard St.

15 Filed ..., 19... C. HAMPSON JONES, M. D.
Registrar

R 10 1529

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16, 1929

17

I HEREBY CERTIFY, That I attended deceased from April 13, 1929, to April 16, 1929, that I last saw him alive on April 16, 1929, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Acute Angina-Cardiac,

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic Endocarditis,

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Symptoms etc.

(Signed) [illegible], M. D.

, 19 (Address) 836 W. Lombard Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL Apr. 16 1929

20 UNDERTAKER Chapline Cook

ADDRESS 1003 West Baltimore St

Spec.—2-29-28—L. F. S.—500 Bks.

Tennon Ville S.C.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45141

1—PLACE OF DEATH

CERTIFICATE OF DEATH

REGISTERED NO. **E 45141**

CITY OF BALTIMORE: (No. 852 Fairmount ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Percy N White

(a) RESIDENCE NO. 852 Fairmount ST., WARD 16

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 21 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col'd	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1911

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	18			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. C.

14 Informant Mrs White

(Address) 852 Fairmount

15 Filed Apr 18 1929 C. HAMPSON JONES, M. D. Registrar

Reg.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 1929

17

I HEREBY CERTIFY, That I attended deceased from April 14 1929, to April 16, 1929, that I last saw h alive on April 16, 1929 and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
Anasarca

CONTRIBUTORY (Secondary) Pulm. Oedema (duration) yrs. mos. ds.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) April 17 1929 H. Norwood, M. D.

(Address) 939 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Florence Cem

DATE OF BURIAL April 17 1929

20 UNDERTAKER Hamel Eutaw

ADDRESS 916 Eutaw

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45142

CERTIFICATE OF DEATH

100

E 45142

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hosp St., 15-21 Ward)

2-FULL NAME Louise Bradford

(a) RESIDENCE NO. 629 Baker St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 Color or Race: Col

5 Single, Married, Widowed or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: No

6 DATE OF BIRTH (month, day, and year): Dec 27-1924

7 AGE — Years: 4 | Months: 3 | Days: 20 | IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town): N. C.
(State or country)

PARENTS

10 NAME OF FATHER: John Bradford

11 BIRTHPLACE OF FATHER (city or town): N. C.
(State or country)

12 MAIDEN NAME OF MOTHER: Jessie Stovall

13 BIRTHPLACE OF MOTHER (city or town): N. C.
(State or country)

14 Informant: Jessie Bradford
(Address): 629 Baker St

Dated ... 19... Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): April 17th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to Death on the day stated above.
The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos One ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos ds.

18 Where was disease contracted if not at place of death? 629 Baker

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) A. Glenk, M. D.

April 19th 1929 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: April 18 1929

20 UNDERTAKER: Saml Easter & Son — ADDRESS 916

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

R 18 1929

Cor.—12-9-28—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 45143

185 ~ E 45143

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Franklin Sq. Hospital 4th (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jas. Jones

(a) RESIDENCE NO. 786 Sarah Ann St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Col	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown 1896

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	33	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lab

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto Co

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Mrs Hall

(Address) 1634 Fairmont Ave

15 Filed [illegible] Registrar

CR 131629

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/15 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Internal injury -
Fell from 2nd floor 1/2 3 Instantly
while removing old rubbish

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....mos. .....ds.

(Signed) Chas H Brooke M. D.
(Coroner)

4/17 1929 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

IS LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — Date of Burial 4-17 1929

20 UNDERTAKER David Carter — ADDRESS 916 Oa ave

OF DEATH in plain terms, so that if may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45144

CERTIFICATE OF DEATH

52

E 45144
REGISTERED NO.

1—PLACE OF DEATH Hammond Apt

CITY OF BALTIMORE: (No. 101 W. 39th St ST. 12-49 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Kingsland White

(a) RESIDENCE NO. 101 W. 39th St ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~ (write the word)
Male	White	Widower

5a If married, widowed, or ~~divorced~~ HUSBAND of (or) ~~WIFE of~~ Late Frances D. White

6 DATE OF BIRTH (month, day, and year) April 2nd 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67		14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER John Campbell White

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mr Walters

(Address) 101 W 39 St

15 Filed ..., 19... C. HAMPSON JONES, M. D., Registrar

R 101929 By ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16th 1929

17 I HEREBY CERTIFY, That I attended deceased from July, 1927, to April 16, 1929, that I last saw h[e] alive on April 10, 1929, and that death occurred, on the date stated above, at 6 30 P m.

The CAUSE OF DEATH* was as follows:

CEREBRAL ARTERIOSCLEROSIS

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) CHR. INFECT. ARTHRITIS

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) D. L. E. Jones, M. D.

April 17, 19 29 (Address) 1129 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	April 19 1929
20 UNDERTAKER Henry Heuisler & Sons Co.	ADDRESS Richard & Fayette Sts

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45145

CERTIFICATE OF DEATH

128

REGISTERED NO. E 45145

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1402 Riggs Ave ST. 16-2 WARD)

2—FULL NAME Jennie Harvey

(a) RESIDENCE NO. 1402 Riggs Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ernest Harvey

6 DATE OF BIRTH (month, day, and year) Unknown 91

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 937

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER James Morris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Ernest Harvey
(Address) 1402 Riggs Ave

15 Filed ..., 19 HAMPTON JONES, M. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 17 1929

17 I HEREBY CERTIFY, That I attended deceased from Apr 7, 1929, to Apr 17, 1929

that I last saw h alive on Apr. 17, 1929

and that death occurred, on the date stated above, at 5:15 p.m.

The CAUSE OF DEATH* was as follows:

Acute Pneumonia

Hemiplegia (duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) B. F. Hatcher M. D.

4/17, 1929 (Address) 1402 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Apr 20 1929
20 UNDERTAKER	ADDRESS
Thos M Chase & Son	1500 Mich

R 12 1929

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45146 E 45146

CERTIFICATE OF DEATH

BALTIMORE CITY HOSPITALS

1—PLACE OF DEATH [redacted] REGISTERED NO. 90

CITY OF BALTIMORE: (No. [redacted] ST. 71-25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alice Bradley

(a) RESIDENCE NO. 333 W. Biddle ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Joshua Duffin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mahala ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Records of
(Address)

15 Filed ..., 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 16, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 30, 19 29 to April 16, 19 29 that I last saw her alive on April 16, 19 29 and that death occurred, on the date stated above, at 9:30 Am.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Decubitus Ulcers

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Marvin M. McClean, M. D.

4-17, 1929 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Apr 20 1929
20 UNDERTAKER	ADDRESS
Harry M. Blackstone	1400 Mosher

BALTIMORE CITY HOSPITALS

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45147

CERTIFICATE OF DEATH

148 E 45147

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hosp. St. 16-23 Ward)

2-FULL NAME Zenobia Stanley

(a) RESIDENCE NO. 1327 W Lanvale St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Fem	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Stanley

6 DATE OF BIRTH (month, day, and year) Feb 9-1900

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	29-	2	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife.
(b) General naturo of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Ely Brown

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Sallie Ridout

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Hosp. Record (Provident Hosp.)
(Address) Division St

15 Filed 19 Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jan 16th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Puerperal Eclampsia

(duration) yrs. mos. One ds.

CONTRIBUTORY (Secondary) Child Birth

(duration) yrs. 8½ mos. ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? Yes Date of Jan 16th

Was there an autopsy? Post Mortem Cesarean done

What test confirmed diagnosis? Clinical Regular

(Signed) F. E. Linthicum, M. D.

Jan 18 1929 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bella. Balto Co	Jan 21 1929
20 UNDERTAKER	ADDRESS
Sam'l W. Chamberlain	Woodlawn

PR 181929 C. HAMPSON JONES, M. D.

Spec.—2-29-28—L. F. S.—500 Blks.

E 45148

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45148

CERTIFICATE OF DEATH

45

1—PLACE OF DEATH 1341 N. Patterson Park Ave. REGISTERED NO.

CITY OF BALTIMORE: (No. ~~1341 N. Patterson Park Ave.~~ ST. 8-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Mullikin

(a) RESIDENCE NO. 1341 N. Patterson Park Ave ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 27, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	7	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Motorman
(b) General nature of industry, business, or establishment in which employed (or employer) United R R Co
(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER —

11 BIRTHPLACE OF FATHER (city or town) —
(State or country)

12 MAIDEN NAME OF MOTHER Ellen Ogle

13 BIRTHPLACE OF MOTHER (city or town) —
(State or country)

14 Informant W. P. Mullikin
(Address) 1341 Patterson Park Ave

Filed APR 18 1929 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 16/29

17 I HEREBY CERTIFY, That I attended deceased from about 14 mos 1929, to Apr 16/29,
that I last saw h. alive on Apr 16. 29, 19
and that death occurred, on the date stated above, at 3:15 P m.
The CAUSE OF DEATH* was as follows:

Arteriosclerosis

about 1 year
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchial Trouble, Com of all the Body
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Wm T. Pulley, M. D.

Apr. 18 1929 (Address) 1059 Penna

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	Apr 19 1929
20 UNDERTAKER George J Smith	ADDRESS 1532 Hollins

Cor.—12-9-25—A Co.—200 Bks.

45149

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 45149

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 6014 Smithore 2nd Floor St. 14-59 Ward)

2-FULL NAME Sarah F Ruson

(a) RESIDENCE NO. 570 Gold St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: C

5 Single, Married, Widowed, or Divorced. (write the word): Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: George F Ruson

6 DATE OF BIRTH (month, day, and year): 1854-5-25

7 AGE — Years: 49 Months: 10 Days: 22 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Md

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Unknown

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town):

(State or country)

14 Informant: F. F. Ruson

(Address) 570 Gold St

15 Filed 19 C. HARRISON JONES, M. D. Registrar

per

PR 181929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-18 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.....find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart (duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) ..... (duration) .....yrs. .....mos. .....ds.

(Signed) C. Harrison Jones, M. D. (Coroner)

4/18, 1929 (Address) 2632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Middletown Md — Date of Burial: April 20 1929

20 UNDERTAKER: C & K Gladhill — ADDRESS: Middletown

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 45150 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

E 45150
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1120 N Carey St. 16-23 WARD)

2-FULL NAME Lewis Randolph Saunders

(a) RESIDENCE No. 1120 N Carey ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 6 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	8		11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ottawa Ill.

PARENTS

10 NAME OF FATHER John Saunders

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bedford City Va.

12 MAIDEN NAME OF MOTHER Margaret Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Margaret Saunders
(Address) 1120 N Carey St.

15 Filed Apr 19, 1929 H. HAMPSON JONES, M. D. Registrar

R 181929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 17 1929

17 I HEREBY CERTIFY, That I attended deceased (from Apr 2, 1929, to Apr 17, 1929, that I last saw h alive on Apr 17, 1929, and that death occurred, on the date stated above, at 11:30 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. W. Chamberlain, M. D.
4/17, 1929 (Address) 1928 Pennsylvania Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn | DATE OF BURIAL: April 19 1929

UNDERTAKER: Francis E. Mayhew | ADDRESS: 1164 N Carey

TION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

45151

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-103

E 45151

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) Franklin Square Hospital Ward

2-FULL NAME Laura (Mrs.) V. Ringgold

(a) RESIDENCE NO. 838 Harlem Pk St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 13 1880

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	45	1	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto. Md

PARENTS

10 NAME OF FATHER Alexander Powell

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Martha Ringgold

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Celeste Roberts

(Address) 322 Madison Ave

Filed APR 16 1929 S. HAMPSON JONES, M.D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/13 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull

Struck by Automobile driven by Mossie J. Carrollton

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) Chas. H. Brooks M. D. (Coroner)

4/17, 1929 (Address) P.O. Box Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Aberdeen Md Date of Burial: April 18 1929

20 UNDERTAKER: Thomas E. Nelson ADDRESS: 1203 Pennsylvania Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Leona Wagner

E 45152 HEALTH DEPARTMENT—CITY OF BALTIMORE E 45152

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH

REGISTERED NO. 6042

CITY OF BALTIMORE: (No. 4404 Glenarm Ave., Raspeburg ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leona Wagner

(a) RESIDENCE NO. 4404 Glenarm Ave. Raspeburg, ST., 26th WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 mule yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fred D. Wagner

6 DATE OF BIRTH (month, day, and year) Feb. 22, 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	62	1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Phillip Amrhein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Friedel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Fred D. Wagner (Address) 4404 Glenarm Ave., Raspeburg, Md.

15 Filed APR 18 1929, 19 HARRISON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17, 19 29

17

I HEREBY CERTIFY, That I attended deceased from April 14, , 19 29 , to April 17, , 19 29 ,

that I last saw her alive on April 16th , 19 29 ,

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. L. Williamson, M. D.

4/17 19 29 (Address) 5713 Belair Rd., Raspeburg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL April 20 29

20 UNDERTAKER Frederick Lazarus Lore — ADDRESS Fullerton

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

R 18 1929

Spec.—2-29-28—L. F. S.—500 Bks.

E 45153

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

10-002 E 45153

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST., 1-V WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ernest C. Bark

(a) RESIDENCE NO. 20 South Curley St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 27, 1917

7 AGE	Years	Months	Days 20	If LESS than 1 day, hrs. or min.
	9	4	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER William Bark

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Cecelia Tabiszak

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant William Bark

(Address) 20 S. Curley St.

15 Filed ..... 19..... [illegible] JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 9, 1929, to April 17, 1929, that I last saw him alive on April 17, 1929 and that death occurred, on the date stated above, at 11.45 a. m.

The CAUSE OF DEATH* was as follows:

Tonsillar & Pharyngeal Diphtheria

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & positive Culture

(Signed) Myron G. Lull, M. D.

4/17, 1929 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cab Jamison	4/19, 1929
20 UNDERTAKER J. J. Moran	ADDRESS 300 E Balto

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45154

CERTIFICATE OF DEATH

E 45154

REGISTERED NO. 129

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 438 N. Highland Ave (STREET) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Jones

(a) RESIDENCE NO. 438 N. Highland Ave STREET WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F | 4 COLOR OR RACE W | 5 Single, Married, Widowed, or Divorced, (write the word) Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Evan Jones

6 DATE OF BIRTH (month, day, and year) Sept 5-1861

7 AGE Years 67 | Months 7 | Days 11 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Boston Mass

PARENTS

10 NAME OF FATHER Daniel Donohue

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Kay O'Brien

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ire

14 Informant Evan Jones
(Address) 438 N Highland Ave

15 Filed [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 1929

17 I HEREBY CERTIFY, That I attended deceased from February 1926 to April 1929

that I last saw her alive on April 17 1929

and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Nephritis Chronic Parenchymatous

Endocarditis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

What there an autopsy? No

What test confirmed diagnosis?

(Signed) W S Mayer M. D.

3/18 1929 (Address) 261 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem | DATE OF BURIAL Apr 20 1929

20 UNDERTAKER J J Moran | ADDRESS 36 E Balto

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45155

CERTIFICATE OF DEATH

E 45155

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hosp. St., 18-26 Ward) 101-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John H. Sample

(a) RESIDENCE NO. 232 Rock St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col.

5 Single, Married, Widowed or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Fannie Sample

6 DATE OF BIRTH (month, day, and year): 1883

7 AGE: Years 46; Months; Days; IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) Accomac Co (State or country) Va.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant: Lula Matthews
(Address) 237 Coon Alley

15 Filed 19 THOMPSON JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Apr 18th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. Schmidt, M. D.

19 Apr 20 '29 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion Cemetery — DATE OF BURIAL: April 18, 29

20 UNDERTAKER: Mrs Kate R Williams — ADDRESS 322 1/2 Schroeder St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

APR 19 1929

Cor.—10-10-29—A Co.—100 Bks.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 45156

90~

E 45156

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1143 McElderry St St. 5-8 Ward)

2-FULL NAME Cornelia W. Anderson

(a) RESIDENCE NO. 1143 McElderry St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	black	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Robert Anderson

6 DATE OF BIRTH (month, day, and year) Nov 25/1867

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	41	4	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Berryville, Va

PARENTS

10 NAME OF FATHER Anthony Williams

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Berryville, Va.

12 MAIDEN NAME OF MOTHER Rosie Williams

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Berryville, Va.

14 Informant Charles Williams (Bro)
(Address) 226 N. Schroeder St

APR 18 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 16/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Autopsy

(Signed) J. E. Owens, M. D.

4/17/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL April 11, 1929

20 UNDERTAKER Mrs. Katie R. Williams

ADDRESS 3 [illegible] N. Schroeder St

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 45157

REGISTERED NO. E 45157

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 2111 N. Calvert ST. 17-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George T. Hancher

(a) RESIDENCE NO. 2111 N. Calvert ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

a If married, widowed or divorced HUSBAND of (or) WIFE of: Susie T.

6 DATE OF BIRTH (month, day, and year): July 29-1865

7 AGE: 63 Years 64 | Months 8 | Days 18 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Traveling

(b) General nature of industry, business, or establishment in which employed (or employer): Salesman

(c) Name of employer: Peters Dry Dock Co

9 BIRTHPLACE (city or town) (State or country): Tennessee

PARENTS

10 NAME OF FATHER: John Hancher

11 BIRTHPLACE OF FATHER (city or town) (State or country): Tennessee

12 MAIDEN NAME OF MOTHER: Jane Ingrem

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. Carolina

14 Informant: Susie T. Hancher

(Address) 2111 N. Calvert St.

15 Filed 4/19 1929 CHAMPION REGISTRAR

Registered No. 161929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 16 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 12, 1928, to April 16, 1929

that I last saw h alive on April 16, 1929

and that death occurred, on the date stated above, at 9.20 P m.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis, Mitral Insufficiency (Decompensation)

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry Hyde, M. D.

4/17, 1929 (Address) 1106 E. Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore County

DATE OF BURIAL: 4/18 1929

20 UNDERTAKER: W. M. Cook

ADDRESS: 1210 Park

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45158

E 45158

182

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Found floating in the water at

City of Baltimore: (No. Foot of William St. off Pier 2 St., [illegible] Ward)

2-FULL NAME Unknown.

(a) RESIDENCE NO. Do not know. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Do not know.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or .... min.
	45	----------	----------	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Do not know.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Do not know.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Police Report. S.D.
(Address)

15 Filed ....., 19 C. HAMPSON JONES, M. D. Registrar

THE MORGUE

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Body found April 5, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning.

Probably accidental.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Investigation.

(Signed) [illegible] M. D.

4/15. 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health.

ADDRESS

APR 18 1929

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 45159 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

18 E 45159

REGISTERED NO._____

1-PLACE OF DEATH Foot of Bowley's Wharf

City of BALTIMORE: (No. Bowley's Wharf St. 1-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME unknown

(a) RESIDENCE NO. unknown St._____ Ward_____

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	white	unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	about 45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Probably Sailor

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer

9 BIRTHPLACE (city or town)_____

(State or country) Probably Sweden

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) unknown

14

Informant_____

(Address)

Date 4/11/1929 C. HAMPSON JONES, M. D.

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 10 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Accidental Drowning

(duration) Sudden yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) James M Rankin M. D.
(Coroner)

4/11/1929 (Address) York & Chase Sts

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

15 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?_____

Former or usual residence_____

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY Date of Burial 19

20 UNDERTAKER Commissioner Health ADDRESS

APR 18 1929

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 1929

Cor.—12-9-25—A Co.—200 Bks.

E 45160

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31-E 45160

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 919 Granby St., 35 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Unknown James M Mullen

(a) RESIDENCE NO. 919 Granby St._____ Ward_____

(Usual place of abode)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
Probably	55 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant

(Address)

Filed 19 H. A. JONES, M. D.

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/7 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows: Probably Tuberculosis Pulmonary

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary)

(duration) ___ yrs. ___ mos. ___ ds.

(Signed) James M Hutton M. D.

(Coroner)

4/8 19 29 (Address) 3017 Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ___ yrs., ___ mos., ___ ds. In the State ___ yrs., ___ mos., ___ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 BURIAL, CREMATION OR REMOVAL Glenwood Cem Balto 4/28/29

Undertaker 3617 Clarinda ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

APR 18 1929

Commissioner of Health

APR 18 19

Registrar

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45161

101-001

CERTIFICATE OF DEATH.

E 45161

REGISTERED NO._____

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. U. of M. City Hospital St. 16-37 Ward)

2-FULL NAME Joseph Mininni (or Unknown)

(a) RESIDENCE NO. Unknown St._____ Ward_____

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
about	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town) Unknown

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant

(Address)

Date APR 15 1929 Signature H. Hyson Jones M. D.

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4 17 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ....yrs. ....mos. 10 ds

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) James M. Fenton M. D.

(Coroner)

4/17 1929 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

UNIVERSITY OF MARYLAND

20 UNDERTAKER — ADDRESS

Commissioner Health APR 18 1929

Per

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor. 2-9-29 Bks. E 45162

Leachinga

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45162

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Balt City Hospital St. 26-37 Ward

2-FULL NAME Anthony Leachinga

(a) RESIDENCE NO. Aberdington Md St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Mak	Whit	unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	83?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer ? 40

(b) General nature of industry, business, or establishment in which employed (or employer) unknown

(c) Name of employer

9 BIRTHPLACE (city or town)_____

(State or country) Aberdington Md

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) unknown

14 Informant unknown

(Address)

Filed APR 18 1929, 19____ Registrar

3488 Reg

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 17 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma ? Stomache

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

(Signed) James M. Renton, M. D.
(Coroner)

417 1929 (Address) 1002 Chan St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death? Aberdington Md

Former or usual residence City 10 Yrs - 6 Yrs

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

UNIVERSITY OF MARYLAND

20 UNDERTAKER — ADDRESS

Commissioner Health APR 18 1929

PER WM. E. WOODS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 45163

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

113 E 45163

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 419 N. Glover St. 6-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edward F. Scherer

(a) RESIDENCE NO. 419 N. Glover ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Baby

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 28 1928

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Philip Scherer

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Anna Knopf.

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant Philip Scherer

(Address) 419 N. Glover St

15 Filed APR 10 1928, 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-17-29

17 I HEREBY CERTIFY, That I attended deceased from 4-13-29, 19, to 4-17-29, 19, that I last saw h[illegible] alive on 4-17-29, 19, and that death occurred, on the date stated above, at 3 0 m.

The CAUSE OF DEATH* was as follows:

Acute Gas Colitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Pertussis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) I. C. Reed Miller M. D.

(Address) 1000 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Emmanuel Cemetery

DATE OF BURIAL April 19 1929

20 UNDERTAKER Jno. C. Miller & Son

ADDRESS 2334 Jefferson

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45164

CERTIFICATE OF DEATH.

31

REGISTERED NO. B 45164

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 107 Ravenna Ave. ST. 27-46 WARD)

2-FULL NAME Margaret Allen Burk

(a) RESIDENCE NO. 107 Ravenna Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. 9 mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 3, 1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
23	24	9	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Henry Stuline

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Co., Maryland.

12 MAIDEN NAME OF MOTHER Margt. T. Krahl

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Co. Md.

14 Informant Daniel E Burk

(Address) 107 Ravenna Ave

Filed . 19 Registrar

R 101529

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-16 1929

17 I HEREBY CERTIFY, That I attended deceased from 4-13, 1929, to 4-16, 1929, that I last saw her alive on 4-16, 1929, and that death occurred, on the date stated above, at 10 10 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 1 hour.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) William E. Cole, M. D.

4-16, 1929 (Address) 6014 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. John Lutheran Cemetery	April 18 1929

20 UNDERTAKER Benjamin Smith ADDRESS

Elmer W Conklin 924 E. Eager St.

CHECK OF CERTIFICATE. This portion of certificate may be detached by Undertaker, but must be preserved by Physician.

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45165

HEALTH DEPARTMENT—CITY OF BALTIMORE

21 E 45165

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Sydenham Hospital ST., 18-76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jack Delmar Gorman

(a) RESIDENCE NO. 876 W. Fayette ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 1 mos. 12 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 31, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	—	1	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER John Gorman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Marie Friese

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hagerstown Md

14 Informant Marie Gorman
(Address) 876 W. Fayette

15 Filed APR 18 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12, 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb 18, 1929, to March 12, 1929, that I last saw h. alive on March 12, 1929 and that death occurred, on the date stated above, at 8 40 p m.

The CAUSE OF DEATH* was as follows:

Erysipelas (of trunk & extremities)

(duration) X yrs. X mos. 25 ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) X yrs. X mos. 4 ds.

18 Where was disease contracted if not at place of death? 876 W. Fayette St.

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis Clinical findings & X ray

(Signed) Addison Craft Irby, M. D.

3-13 1929 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — PUBLIC CEMETERY — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

Commissioner Health

APR 18 1929

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45166

CERTIFICATE OF DEATH

101-201

E 45166

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Windsor Court Apts.

CITY OF BALTIMORE: (No.) 2901 (St.) Garrison Ave (Ward) 15-64

2-FULL NAME Harry Clifford Marke

(a) RESIDENCE NO. 2901 ST. Garrison Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred 29 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret L. Marke

6 DATE OF BIRTH (month, day, and year) June 14 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	64	10	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Accounting Dept.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B & O. R. R.

9 BIRTHPLACE (city or town) (State or country) Penn Ohio

PARENTS

10 NAME OF FATHER Wm J. Marke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Marie Power

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Margaret L. Marke

(Address) 2901 Garrison Ave

15 Filed G. HAMSON JONES, M. D. Registrar

R 181929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18th 1929

17

I HEREBY CERTIFY, That I attended deceased from April 13, 1929, to April 18, 1929, that I last saw h[illegible] alive on April 17, 1929 and that death occurred, on the date stated above, at m

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. K. Cadell M. D.

4/19/29 (Address) 2757 W. Monroe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	4/20 1929

20 UNDERTAKER Chas F. Kane & Son ADDRESS 1180 W. Mt Royal Ave

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 45167

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45167

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 901 Aisquith St.) (WARD) 10-14

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sister Mary Thomasita Hewitt

(a) RESIDENCE NO. Motherhouse of Notre Dame ST., WARD Boston Mass.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 4 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 30, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	10	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher

(b) General nature of industry, business, or establishment in which employed (or employer) Religious

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Batavia N. Y.

PARENTS

10 NAME OF FATHER Michael Hewitt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Birmingham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Sister of Notre Dame
(Address)

15 Filed 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 1929

17

I HEREBY CERTIFY, That I attended deceased from December 10. 1928 to April 16 1929, that I last saw her alive on April 16. 1929, and that death occurred, on the date stated above, at 6:45 P.M. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
Myocarditis -

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) J. F. Kirby, M. D.

4/17, 1929 (Address) 110 E. Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Notch Cliff Md. DATE OF BURIAL April 19 1929

20 UNDERTAKER Frank A. Fink ADDRESS 915 N. Gay St.

TION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks. Sister Mary Alexine

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 45168 47 **E 45168**

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 97-48 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sister Mary Alexine

(a) RESIDENCE NO. Notre Dame Md St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE: Years 53 Months Days IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Religious

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Boston

(State or country) Mass

PARENTS

10 NAME OF FATHER John Gormley

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Doyle

13 BIRTHPLACE OF MOTHER (city or town) Boston

(State or country) Massachusetts

14 Informant Sister M. Philemon

(Address) Notre Dame of Md. Balto. Md

R 187929 C. HAMPSON JONES, Registrar.

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/17/29 19

17 I HEREBY CERTIFY, That I attended deceased from 4/15/29 19 to 4/17/29 19,

that I last saw h alive on 4/17/29 19,

and that death occurred, on the date stated above, at 11 m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) 6 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of 4/16/29

Was there an autopsy?

What test confirmed diagnosis? Pathologic

(Signed) , M. D.

, 19 (Address)

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Govens town Prince | Date of Burial: April 20 1929

20 UNDERTAKER: Frank A. Fink | ADDRESS: 915 W. Lex

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 45169 HEALTH DEPARTMENT—CITY OF BALTIMORE E 45169

CERTIFICATE OF DEATH.

REGISTERED NO. 161

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1727 E Pager ST. 7-13 WARD)

2-FULL NAME Bulay Brodow

(a) RESIDENCE NO. 1727 E Pager ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 hrs. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 16 1929

7 AGE	Years	Months	Days	If LESS than 1 day, 4 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Wm E Jackson

11 BIRTHPLACE OF FATHER (city or town) Balto Md (State or country)

12 MAIDEN NAME OF MOTHER Cather Jackson

13 BIRTHPLACE OF MOTHER (city or town) Balto Md (State or country)

14 Informant Milton Davis (Undertaker) (Address) 4131 Edison St

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16 1929

17 I HEREBY CERTIFY, That I attended deceased from April 16, 1929, to April 16, 1929, that I last saw him alive on April 16, 1929, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Premature Labor

(duration) 9 Preg yrs. 9 mos 6 ds.

CONTRIBUTORY (Secondary) unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R J Young M. D.

4/18 1929 (Address) 1429 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ashbury Cemetery DATE OF BURIAL April 18 1929

20 UNDERTAKER Milton Davis ADDRESS 4131 Edison St

R 181929 C. HAMPSON JONES, M. D. Registrar

CAUSE OF DEATH must be plainly stated, so that it may be properly classified. EXACT statement of ONSET, etc., is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45170

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

E 45170

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Southern Hospital (Ward) 9-10

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Roberta Jeffrey

(a) RESIDENCE NO. Southern Hospital WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mns. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): single

6 DATE OF BIRTH (month, day, and year): not known

7 AGE — Years: 89 — Months — Days — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: not any

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md Harford Co.

PARENTS

10 NAME OF FATHER: Thomas Jeffrey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Sarah Coles

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: S. G. Mumaw

(Address): Bel Air Md

15 Date Apr 19 1929 C. HAMPSON JONES, M. D. Registrar

R 181929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 18, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 17th, 1929, to April 18th, 1929, that I last saw h[illegible] alive on April 17th, 1929, and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Uremia — cardio renal disease —

(duration) unknown yrs. mns. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no —

What test confirmed diagnosis? none —

(Signed) John T. Timmis M. D.

Apr 19th 1929 (Address) 111 Beechdale Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional spaces.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Md Emmorville Harford Co.

DATE OF BURIAL: Apr 19 1929

20 UNDERTAKER: John C. Mitchell

ADDRESS: Essex 1900 Eastern

Spec.—2-29-28—L. F. S.—500 Bks.

E 45171 Med

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

63 E 45171

1—PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST. 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rhoda Pershing

(a) RESIDENCE NO. 708 N 6th St ST., WARD Shamokin Pa
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. mos. 12 ds. How long in U. S., if foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

a If married, widowed, or divorced HUSBAND of (or) WIFE of John F

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H W.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER Frank Strauss

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Kendle Yeend

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Relative

(Address) JOHNS HOPKINS HOSPITAL

15 C. HAMPSON JONES, M. D.
Registrar

R 181929 Par

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18-1929

17

I HEREBY CERTIFY, That I attended deceased from April 6, 1929, to April 18 1929, that I last saw h-- alive on April 18, 1929, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Addisons Disease

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Entire Clinical Picture

(Signed) Henry G. Hoeckenberg, M. D.

4/18 1929 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Shamokin Pa

DATE OF BURIAL 4/18/29

20 UNDERTAKER Joseph Ahrens

ADDRESS 221 Bway

Spec.—2-29-28—L. F. S.—500 Bks.

E 45172

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 45172

REGISTERED NO. 15-64

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3106 Gwynns Falls Pkwy ST., WARD)

2—FULL NAME Edna May Weber

(a) RESIDENCE NO. 3106 Gwynns Falls Pkwy ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. 10 mos. 8 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 6-1905

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	23	10	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Charles J. Weber

11 BIRTHPLACE OF FATHER (city or town) (State or country) Buckley Illinois U.S.A.

12 MAIDEN NAME OF MOTHER Lucy J. Widmyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland U.S.A.

14 Informant Charles J. Weber

(Address) 3106 Gwynns Falls Parkway

15 Filed G. H. A. MPSON JOHNS, Registrar

2181929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18-29

17 I HEREBY CERTIFY, That I attended deceased from Mch 1, 1929, to April 18, 1929, that I last saw h alive on April 17, 1929 and that death occurred, on the date stated above, at 11 A M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Alan B Pearson, M. D.

4/18, 1929 (Address) 718 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	Apl. 20 1929
20 UNDERTAKER Harry W. Ehlen	ADDRESS 1945 W. Nor. Ave.

Spec.—1-10-21 M&T 1500 Blks.

E 45173

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

104-002

E 45173

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 356 Cleveland St., 21-29 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Thomas

(a) RESIDENCE NO. 356 Cleveland ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE Col

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 11 1927

7 AGE Years 1 Months 6 Days If LESS than 1 day, ...hrs or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Ben Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Bundell Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Bud Jones (Address) 356 Cleveland

15 Filed APR 18 1929 By C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/16/29

17 I HEREBY CERTIFY, That I attended deceased from 4/13/29, to 4/16/29, that I last saw him alive on 4/16/29, and that death occurred, on the date stated above, at 130 p m.

The CAUSE OF DEATH* was as follows:

Septic Fossil Abscess

Septic Infection

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Clifford Downs, M. D.

, 19 (Address) 1717 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery

DATE OF BURIAL 4/19 1929

20 UNDERTAKER Walter B. Griggs

ADDRESS 189 W. Hamburg St

TION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 45174 — REGISTERED NO. E 45174

1-PLACE OF DEATH

City of BALTIMORE; (No. 1358 Cleveland St. Ward 21-24)

2-FULL NAME Marie Randolph

(a) RESIDENCE NO. 1358 Cleveland St. Ward

(Usual place of abode)

(If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Chas. H. Randolph

6 DATE OF BIRTH (month, day, and year): June 10 1899

7 AGE: Years 30 Months 3 Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: W. W.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Josia Taylor

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Md

12 MAIDEN NAME OF MOTHER: Mrs Brown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Md

14 Informant: Chas. H. Randolph

(Address): 1358 Cleveland St

C. HAMPSON JONES, M. D.

Per Registrar

R 181929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/15 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry.)

thereon, and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hodgkin's Disease

Myocardial Insufficiency

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) Chas W Brosius M. D.

(Coroner)

4/17 1929 (Address) S. W. Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary — Date of Burial: Apr 17 '29

20 UNDERTAKER: Walter B. Spiggs — ADDRESS: 1394 Hanover St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPAT is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45175

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45175

CERTIFICATE OF DEATH

1—PLACE OF DEATH South Baltimore General Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 1213 Light ST. 27-56 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Susan Humes

(a) RESIDENCE NO. 5102 Palmer Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	~~widow~~ Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 8, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	2	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. Accidental fall at home Jan 1929

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Samuel Humes

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Mary Pritchard

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Hospital Records
(Address)

15 1929 C. HALPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 10, 1929, to April 16, 1929.

that I last saw her alive on April 16, 1929

And that death occurred, on the date stated above, at 3 10 A. m.

The CAUSE OF DEATH* was as follows:

Fractured femur (right)

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical and X Ray.

(Signed) Nathan N. Cohan, M. D.

4-16-, 1929 (Address) So Balt Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem.

DATE OF BURIAL 4/19 1929

20 UNDERTAKER Harry A. Mitzka

ADDRESS 531 W. Lombard St.

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 45176

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45176

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

REGISTERED NO.....

CITY OF BALTIMORE: (No. 1324 W. Lombard St. 19-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Wesley Arther

(a) RESIDENCE. No. 1324 W. Lombard ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ Martha E. Arther

6 DATE OF BIRTH (month, day, and year) Oct. 31, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	5	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) Rep. Shop, 31

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Arther

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Weir

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Martha E. Arther (wife)

(Address) 1324 W. Lombard St

15 Filed 181929 C. HAMPSON JONES, M. D. Registrar

By RHH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 16 1929

17 I HEREBY CERTIFY, That I attended deceased from March 29, 1929, to Apr. 16, 1929, that I last saw him alive on Apr. 16, 1929, and that death occurred, on the date stated above, at 8:30 p. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Coronary Thrombosis

(duration) yrs. mos. 10 hrs

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical Signs

(Signed) W. S. Dipietro, M. D.

4/17, 1929 (Address) 1324 W. Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: 4/19 29

20 UNDERTAKER: Harry N. Witzke — ADDRESS: 1531 W Lombard St.

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 45177 HEALTH DEPARTMENT—CITY OF BALTIMORE E 45177

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Agnes Hospital 4-16-67 ST. WARD) 101 001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Katharine Chittick.

(a) RESIDENCE No. 3001 W. Prentman St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, Widowed, ~~or Divorced~~, (write the word)
Female	White	Widow.

5a If married, widowed, or divorced HUSBAND of or) WIFE of late Mon. J. Chittick

6 DATE OF BIRTH (month, day, and year) Feb. 19, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	67	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Michael Schaaies

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Moran

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant William E. Chittick

(Address) 3001 Prentman St.

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18 1929

17

I HEREBY CERTIFY, That I attended deceased from 4-15-29, 1929, to 4-18-29, 1929, that I last saw her alive on April 17th, 1929, and that death occurred, on the date stated above, at 3 A. M. m.

The CAUSE OF DEATH* was as follows:

Nephritis. Chronic Interstitial

Adenitis Chronic

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pneumonia Lobar

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) R. M. Grissom, M. D.

4/18, 1929 (Address) Kramer Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Herrick Ridge

DATE OF BURIAL 4/22 1929

20 UNDERTAKER Harry N. White, 1531 W. Fairmount Ave

ADDRESS

L 81923

E. HARRISON JONES, M. D.

Registrar

TION IS very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45178 HEALTH DEPARTMENT—CITY OF BALTIMORE 74-29 ✓ **E 45178**

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1403 N. Mount ST. 15-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Hopkins

(a) RESIDENCE NO. 1403 N. Mount ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Augusta Hopkins

6 DATE OF BIRTH (month, day, and year) Mar 12, 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	1	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) O+O

(c) Name of employer

9 BIRTHPLACE (city or town) Richmond (State or country) Virginia

PARENTS

10 NAME OF FATHER Samuel Hopkins

11 BIRTHPLACE OF FATHER (city or town) Amelia Co. (State or country) Virginia

12 MAIDEN NAME OF MOTHER Lucinda Willis

13 BIRTHPLACE OF MOTHER (city or town) Amelia Co (State or country) Virginia

14 Informant Mrs Augusta Hopkins (Address) 403 N. Mount St.

15 Filed APR 19 1929 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-16-29

17 I HEREBY CERTIFY, That I attended deceased from 4-15- , 1929. to 4-16- , 1929. that I last saw him alive on 4-16- , 1929 and that death occurred, on the date stated above, at 5.45 p. m.

The CAUSE OF DEATH* was as follows:

arterio-sclerosis

(cerebral hemorrhage)

(duration) not known yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? physical signs & symptoms

(Signed) John G. L. Campbell M. D.

. 19 (Address) 724 N. Carrollton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery — DATE OF BURIAL April 19 1929

20 UNDERTAKER Thomas E. Kelson — ADDRESS 1307 Eastman St

Spec.—1-10-21—M&T—1500 Bks.

E 45179 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH. 90 (N. Fremont) **E 45179**

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1806 Fruit Ave. St. 15 Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rose Chase

(a) RESIDENCE NO. 1806 Fruit Ave St. WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (Write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Francis M. Chase

6 DATE OF BIRTH (month, day, and year): 1876

7 AGE: Years 57 Months Days If LESS than 1 day, ... hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer: "

9 BIRTHPLACE (city or town) (State or country): Ft. Myers Co Virginia

PARENTS

10 NAME OF FATHER .....

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER .....

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Frank Chase

(Address) 1806 N. Fruit Ave

Filed 4/18/1929 C. HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/17/29

17 I HEREBY CERTIFY, That I attended deceased from 4/20/28 to 4/17/29.

that I last saw her alive on 4/15/29

and that death occurred, on the date stated above, at 7:30 P.M.

The CAUSE OF DEATH* was as follows:

Cardio Nephritis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary): Myocarditis

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No. What test confirmed diagnosis? Clinical

(Signed) H. Lee Hill, M. D.

(Address) 9 N. Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Peters Cemetery — DATE OF BURIAL: April 20, 29

20 UNDERTAKER: Thomas E. Kelson — ADDRESS: 1323 Pennsylvania Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 45180

CERTIFICATE OF DEATH

E 45180

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

CITY OF BALTIMORE: (No. 16-6 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna Kestler

(a) RESIDENCE NO. 2743 Winchester ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Uknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Pennsylvania

PARENTS

10 NAME OF FATHER: John Bishop

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Anna

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Records of

(Address) BALTIMORE CITY HOSPITALS

15 Filed APR 19 1929 G. HA[illegible] Registrar.

By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 15, 1929

17 I HEREBY CERTIFY, That I attended deceased from February 21, 1928, to April 15, 1929, that I last saw her alive on April 15, 1929 and that death occurred, on the date stated above, at 10:20 P m.

The CAUSE OF DEATH* was as follows:

Broncho - Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) Marvin M. McLean, M. D.

, 19 (Address) BALTIMORE CITY HOSPITALS

*State the **Disease Causing Death, or in deaths from Violent Causes**, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dunbaltimore

DATE OF BURIAL: 4/19 19 29

20 UNDERTAKER: D. J. Cook

ADDRESS: 127 E. Fayette

Important: See instructions on back of certificate

Spec.—2-29-28—L. F. S.—500 Bks.

McCarty 123 37

E 45181

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45181

CERTIFICATE OF DEATH

REGISTERED NO. _____

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2911 West North Ave (ST.) 8-16 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Susie E. White

(a) RESIDENCE NO. 2911 West North Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6 DATE OF BIRTH (month, day, and year): Sept 4-1858

7 AGE: Years 70 | Months 7 | Days 14 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Benjamin Fitchugh

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Nancy Hubbard

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Mrs S E Reed

(Address) 5205 Guyon Oak Ave

15 Filed 4-20-1929 C. HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 18-1929

17 I HEREBY CERTIFY, That I attended deceased from Apr 15, 1929, to Apr 18, 1929, that I last saw h alive on Apr 17, 1929 and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Cholecystitis - Chronic -

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Gall stones -

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Harry K McCarty, M. D.

4-18-1929 (Address) 87 W. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery

DATE OF BURIAL: 4/20 1929

20 UNDERTAKER: William Cook

ADDRESS 1217 St Paul St

Spec.—2-29-28—L. F. S.—500 Bks.

E 45182

HEALTH DEPARTMENT—CITY OF BALTIMORE

90

E 45182

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 840 S Paca ST. 21-29 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary E. Bannon

(a) RESIDENCE NO. 840 S. Paca ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jul 16 1862

7 AGE — Years: 67 | Months: 2 | Days: 1 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Laurence Bannon

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Bridget Burke

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Elizabeth Becker
(Address): 840 South Paca St.

15 Filed ..., 19... [illegible] JONES M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 17/29

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 19 28, to April 17, 19 29, that I last saw h[illegible] alive on April 16, 19 29 and that death occurred, on the date stated above, at 4:20 A m.

The CAUSE OF DEATH* was as follows:

Chr. Endocarditis

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary): Myocarditis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Auscultation, Pulse, Clinical Symptoms

(Signed) J. M. Dellett, M. D.

April 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Peters Cemetery — DATE OF BURIAL: April 20 1929

20 UNDERTAKER: William Cook — ADDRESS: 1212 Park Ave

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45183

CERTIFICATE OF DEATH.

90 E 45183

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 304 Robert ST. 14-54 WARD)

2-FULL NAME Zula E. Harris

(a) RESIDENCE NO. 304 Robert ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Charles E. Harris

6 DATE OF BIRTH (month, day, and year) — — 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
51 50	—	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Afford Md

PARENTS

10 NAME OF FATHER John Varner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Afford Md

12 MAIDEN NAME OF MOTHER Mary Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Afford Md

14 Informant Charles E. Harris

(Address) 304 Robert St.

15 Filed 19 Per

C. HAMPSON JONES, M. D. Registrar

R 19929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16. 1929

17 I HEREBY CERTIFY, That I attended deceased from 3/11 ..., 1929, to 4/16 ..., 1929, that I last saw her alive on 4/16 ..., 1929, and that death occurred, on the date stated above at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Organic heart disease (duration) 4 yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Lee Ellis, M. D.

4/16, 1929 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

20 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	4/19 1929

21 UNDERTAKER Samuel Wensley ADDRESS 5[illegible] W Baltimore St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Statement of contributory causes is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 45184

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

V E 45184

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH

City of Baltimore: (No. 1633 Madison Ave. St.) 14-20 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry C. McCorkle

(a) RESIDENCE NO. 1633 Madison Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elsie.

6 DATE OF BIRTH (month, day and year): Oct 6 - 1892

7 AGE: Years 36 | Months 6 | Days 11 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) S. C.
(State or country)

PARENTS

10 NAME OF FATHER: S. R. McCorkle

11 BIRTHPLACE OF FATHER (city or town) S. C.
(State or country)

12 MAIDEN NAME OF MOTHER: Sarah Bailey

13 BIRTHPLACE OF MOTHER (city or town) S. C.
(State or country)

14 Informant: Elsie McCorkle
(Address) 1633 Madison Ave

Filed APR 19 1929 E. HAMPTON EARLY, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) April 17th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Acute Indigestion (duration) ..... yrs. Few hours

CONTRIBUTORY (Secondary) Error of diet. (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Regular

(Signed) A. Gilchrist, M. D.
April 19 1929 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem — DATE OF BURIAL: April 20 1929

20 UNDERTAKER: Samuel Weinsky — ADDRESS: 558 Eddie

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45185

90 ✓

CERTIFICATE OF DEATH

E 45183
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Hopkins Hospital St., 7-13 (Ward)

2-FULL NAME Addie Sampson

(a) RESIDENCE NO. 911 Shutter St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: B

5 Single, Married, Widowed or Divorced, (write the word): married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Samuel Sampson

6 DATE OF BIRTH (month, day, and year) Nov 2/1891

7 AGE: 37 Years 38 Months 5 Days 13 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Maid 07
(b) General nature of industry, business, or establishment in which employed (or employer): Hopkins Hospital
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Frederick Co.,

PARENTS

10 NAME OF FATHER: Dennis Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Frederick Co. Md.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Fred. Co., Md.

14 Informant: McKonley Fields
(Address): 910 Shutter St

15 Filed ..... 19..... (Signature) ..... Registrar

R 131929

Per .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 15/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis

(Autopsy at Hopkins)

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) J. H. Bovie, M. D.

4/17/29 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Int Calvary Lem	4-19 1929
20 UNDERTAKER	ADDRESS
Wm J. G. Lockhart	502 Jefferson st

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

45186

CERTIFICATE OF DEATH

12 9 E 45186

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 435 N. Glover (ST.) 6-10 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Feige

(a) RESIDENCE NO. 435 N Glover ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Feige

6 DATE OF BIRTH (month, day, and year) Sept. 23 1867

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
61	6	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER John Moeser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant George Feige (Address) 435 N. Glover St.

15 Filed ... 19 ... Registrar.

PR 19 1929 C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 17 29

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1929, to Apr 17, 1929, that I last saw her alive on Apr 13 - 1929 and that death occurred, on the date stated above, at 8 p.m.

The CAUSE OF DEATH* was as follows:

Chr Nephritis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Cystitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) [illegible] M. D.

19 (Address) 1430 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cem.

DATE OF BURIAL Burial 20 1929

20 UNDERTAKER Wm. E. Miller & Son

ADDRESS 2334 Jefferson St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

118-002

E 45187
1-PLACE OF DEATH

CERTIFICATE OF DEATH

E 45187
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of Baltimore: (No.) 1226 W. La Fayette St. 16-23 Ward

2-FULL NAME Geo. E. Green Jr.

(a) RESIDENCE NO. 1226 W La Fayette St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of No

6 DATE OF BIRTH (month, day and year) Mar 8 1928

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
		1	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Geo. E. Green

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER Lucy Dugan

13 BIRTHPLACE OF MOTHER (city or town) Pittsburgh
(State or country) Pa

14 Informant Lucy Dugan
(Address) 1226 W La Fayette St

15 [illegible] 16 C. HAMILTON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Mar 8 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to. his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Acute Intestinal Obstruction

(duration) ..... yrs. ..... mos. 1 ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? None
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Regular
(Signed) Chas. Funk, M. D.
Mar 8 1929 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Mar 11 1929
20 UNDERTAKER	ADDRESS
Chas. H. Close Son	[illegible]

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PR 19929

Spec.—2-29-28—L. F. S.—500 Bks.

E 45188

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 E 45188

CERTIFICATE OF DEATH

BALTIMORE CITY HOSPITALS

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST., 16-29 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Louis Jackson

(a) RESIDENCE NO. 620 N. Vincent ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. ... mos. ... ds. How long in U. S., if foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
52				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records of

(Address) BALTIMORE CITY HOSPITALS

Filed APR 19 1929 HANSON JONES, M. D.

By ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 4, 29, to April 16, 29

that I last saw him alive on April 16, 29

and that death occurred, on the date stated above, at 6:40 P m.

The CAUSE OF DEATH* was as follows:

Gastric Hemorrhage
Chronic myocarditis

(duration) a yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) (?) Syphilis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) J. Marvin W. McLean, M. D.

, 19 (Address)

BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL April 20th 29

20 UNDERTAKER A. Jones — ADDRESS 111 S Gilmor

Spec.—2-29-28—L. F. S.—500 Bks.

Welzenbach

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45189

CERTIFICATE OF DEATH

E 45189

REGISTERED NO.

1—PLACE OF DEATH 22 Jewish Hospital

CITY OF BALTIMORE: (No. Lehmann & St. Ward 5)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary L Welzenbach

(a) RESIDENCE NO. 1323 E Eager St. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 1 mos. 26 How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Adam F. Welzenbach

6 DATE OF BIRTH (month, day, and year) February 22 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	1	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John G. Thuber

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Miss Breitbach

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant M. Adam F. Welzenbach

(Address) 1323 E Eager St

15 Date received 1929 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 18 1929

17 I HEREBY CERTIFY, That I attended deceased from 4-13-29 19 to 4-18-29 19

that I last saw h alive on 4-18-29 19

and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 15 yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetic Gangrene of Arm

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of None

Was there an autopsy? No

What test confirmed diagnosis? Clinical Course

Apr 18 1929 Signed J B Hendrix, M. D.

(Address) Jewish Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Apr. 20 1929
20 UNDERTAKER Henry Hoeck Sons Inc.	ADDRESS 1301 E Eager St

Spec.—2-29-28—L. F. S.—500 Bks.

E 45190

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 45190

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1106 N. Central Ave ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Helen M. Traeger

(a) RESIDENCE NO. 1106 N. Central av ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 61 yrs. 5 mos. 27 ds. How long in U. S., if foreign birth yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of John M. Traeger

6 DATE OF BIRTH (month, day, and year) Oct. 21 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	5	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife - 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Joseph Koenig

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dorothy Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. John M. Traeger

(Address) 1106 N. Central ave

15 Filed APR 19 1929 CHARLTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18 1929

17 I HEREBY CERTIFY, That I attended deceased from Apr. 9, 1929, to Apr 18, 1929; that I last saw her alive on Apr. 17, 1929 and that death occurred, on the date stated above, at 1.15 a m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Benj. D. Hayden, M. D.

4/18, 1929 (Address) 216 N. Caroline st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	April 22 1929
20 UNDERTAKER	ADDRESS
Henry Hoeck Sons Inc.	1301 E Eager St.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45191

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 ✓ E 45191

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 813 N. Calhoun ST. 16-23 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Nellie C. Branch

(a) RESIDENCE NO. 813 N. Calhoun ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Lonnie Branch

6 DATE OF BIRTH (month, day, and year) April 2, 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	--	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Gloucester Co. Va.

PARENTS

10 NAME OF FATHER John Cully

11 BIRTHPLACE OF FATHER (city or town) (State or country) Gloucester Co. Va.

12 MAIDEN NAME OF MOTHER Nellie Carter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Glou. Co. Va.

14 Informant Milton Branch

(Address) 813 N. Calhoun St.

15 Filed 19 C. HAMPSON JONES, M. D.

APR 19 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 16, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 4, 1929, to April 16, 1929, that I last saw her alive on April 16, 1929, and that death occurred, on the date stated above, at 10 p. m.

The CAUSE OF DEATH* was as follows:

Cardiac Decompensation

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical exam.

(Signed) Walter J. Jackson M. D.

19 (Address) 1631 W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Zion	April 19 1929

20 UNDERTAKER Joseph A. Lucky ADDRESS 709 N. Mount St

Cor.—10-10-29—A Co.—100 Bks.

E 45192

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45192

CERTIFICATE OF DEATH

100-001

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH

City of Baltimore: (No. Providence Hosp St. 18-22 E Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John H Smith,

(a) **RESIDENCE NO.** 1034 Gelston St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of No

6 DATE OF BIRTH (month, day and year) Sept 11-1926

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	2	7	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Bettond,
(State or country) Mont Smith

PARENTS

10 NAME OF FATHER Mont Smith

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Annie Smith

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Annie Smith
(Address) 1034 Gelston St

15 Filed APR 19 1929 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) April 18th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to h.. death on the day stated above.
The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(duration) yrs. mos. Hours

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. dys.

18 Where was disease contracted if not at place of death? 1034 Gelston St

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Regular

(Signed) Fred Leick, M. D.

April 18th 1929 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary Cemetery — DATE OF BURIAL April 20, 1929

20 UNDERTAKER Mrs. Kate R. Williams — ADDRESS 322 E Lanvale St

Cor.—12-9-25—A Co.—200 Bks.

E 45193

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 45193

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) Pronounced dead at University Hospital St. 13-20 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Richard Armstrong Harris

(a) RESIDENCE NO. 615 Lennox Street St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 76 yrs. 8 mos. 7 ds. How long in U. S., if of foreign birth? 76 yrs. 8 mos. 7 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Betty E. Harris

6 DATE OF BIRTH (month, day, and year) Aug-10-1852

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	76	8	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Book-keeper

(b) General nature of industry, business, or establishment in which employed (or employer) Paper business

(c) Name of employer Dobler & Mudge

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph Harris

11 BIRTHPLACE OF FATHER (city or town) ? ?

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Elizabeth Armstrong

13 BIRTHPLACE OF MOTHER (city or town) ? ?

(State or country) Ireland

14

Informant Mrs. Betty E. Harris (wife)

(Address) 615 Lennox Street

Date April 17 1929

C. HANSON JONES, M. D.

Registrar

PR 191525

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

Contributory (Secondary) Bronchial Pneumonia (duration) 3 days

Operation (Date performed) Apr 11 29 yrs. mos. ds.

Witnessed by Dr Gladden (Coroner) M. D.

19 (Address) 1438 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death 0 yrs., 0 mos., 0 ds. In the State 76 yrs., 8 mos., 7 ds.

Where was disease contracted, if not at place of death? Unknown

Former or usual residence 615 Lennox Street

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery Date of Burial Apr 21/29 19

20 UNDERTAKER HARK & MOWEN COMPANY (WILLIAM F. WOODEN, Successor) ADDRESS 103 W. NORTH AVE.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45194

CERTIFICATE OF DEATH

E 45194

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat ST., 28-65 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Ann Brannigan

(a) RESIDENCE NO. Mt Hope Retreat ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 43 yrs. — mos. — ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

Providence R I

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): —

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	Unknown		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Religious 965

(b) General nature of industry, business, or establishment in which employed (or employer): Household

(c) Name of employer: None Unknown

9 BIRTHPLACE (city or town) (State or country): Unknown Ireland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown Unknown

14 Informant: Mt Hope Retreat

(Address): Mt Hope Retreat

15 APR 19 1929 H. Haven Jones, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 18 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1924, to April 15, 1929, that I last saw h er alive on April 15, 1929 and that death occurred, on the date stated above, at 8.50 P m.

The CAUSE OF DEATH* was as follows:

Diabetes

Unknown

Unknown (duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Dementia

— (duration) 40 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Chemical

(Signed) Milton P. Stella M. D.

, 19 (Address) Mt Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Providence R. I.	Apr 19, 1929.
UNDERTAKER: Edward Mowers	ADDRESS: Balto.

Spec.—2-29-28—L. F. S.—500 Bks.

22/84/ E 45195

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

161-001 E 45195

1—PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 3-4 WARD)

2—FULL NAME Lillian - Hartlove

(a) RESIDENCE NO. 721 S- Bond ST., 2 WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 2 8 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 20 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
		2	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md -

PARENTS

10 NAME OF FATHER George Hartlove

11 BIRTHPLACE OF FATHER (city or town) Md - (State or country)

12 MAIDEN NAME OF MOTHER Eliz. Lawler

13 BIRTHPLACE OF MOTHER (city or town) Md - (State or country)

14 Informant Friends -

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 4/19 1929 C. HANSON JONES, M. D. Registrar

Per Full

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15-29

17 I HEREBY CERTIFY, That I attended deceased from Jan 25, 1929, to April 15 1929

that I last saw her alive on April 15, 1929

and that death occurred, on the date stated above, at 4 35 P. M.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. C. Goodwin, M. D.

4/18, 1929 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cem	April 19 29
20 UNDERTAKER	ADDRESS
Lilly & Gaither Inc.	405 E. Monument

Spec.—1-12-23—M&T—500 Bks.

E 45196

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

REGISTERED No. E 45196

1-PLACE OF DEATH St. Agnes Hospital

CITY OF BALTIMORE: (No. 2929 Winchester ST. 16-67 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Dempsey.

(a) RESIDENCE No. 2929 Winchester ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND) of or) WIFE of Ann. Giles Dempsey

6 DATE OF BIRTH (month, day, and year) Dec 27-1881

7 AGE 47

Years	Months	Days
48	3	22

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Operator

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) W. Va.

PARENTS

10 NAME OF FATHER Michael Dempsey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret McAuliffe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Ann. Giles Dempsey

(Address) 2142 Harford ave.

15 Filed 4/20, 19 29 H. LEON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18th 1929

17 I HEREBY CERTIFY, That I attended deceased from 4-6-29, 1929, to 4-18-29, 1929, that I last saw h alive on April 17th, 1929, and that death occurred, on the date stated above, at 2:20 a. m.

The CAUSE OF DEATH* was as follows:

Arterio. sclerosis

Tuberculosis Pulmonary

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pneumonia Lobar

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. M. Ericson, M. D.

, 19 (Address) St. Agnes Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral

DATE OF BURIAL 4/20 1929

20 UNDERTAKER Henry C Bramwell Inc. Poplar Grove St

ADDRESS 1136

TION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45197 CERTIFICATE OF DEATH. E 45197

1-PLACE OF DEATH WHITE'S HOSPITAL

CITY OF BALTIMORE: (No.) 1029 Madison Ave ST. 11-24 WARD) 161

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Sands

(a) RESIDENCE No. 1022 Madison Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	1929	Apr.	14-1/2 Hrs.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Milton Simmons

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Francis Sands

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant

(Address)

15 Filed 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 18, 1929

17

I HEREBY CERTIFY, That I attended deceased from , 19 .., to , 19 ,

that I last saw h alive on , 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Premature About 5 and 1/2 Mo

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Undevelop an Congenital Atlectasis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. White M. D.

, 19 (Address) 1029 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health.

ADDRESS APR 19 192

Per A. E. Woodall

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

R 191929 H. HAMPSON JONES, M. D.

3195 Registrar

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH E 45198

REGISTERED NO. E 45198

City of BALTIMORE: (No. Mercy Hosp St. 26-37 Ward)

2-FULL NAME Geo. Parker — Robt. Johnson

(a) RESIDENCE NO. _____ St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col.

5 Single, Married, Widowed, or Divorced, (write the word): W

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years: 45? — Months — Days — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Waiter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) _____ (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) _____ (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) _____ (State or country)

14 Informant _____ (Address)

Filed _____, 19__ _____ Registrar

APR 19 1929 MORGUE

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 13th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Pancreatitis Pancreatitis

or Traumatic Abdomen (duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary) 1 day

(duration) ..yrs. ..mos. ..ds.

(Signed) _____ M. D. (Coroner)

, 19 29 (Address) 1699 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..yrs. 1 day. ..mos. ..ds. In the State ..yrs. ..mos. ..ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial 19

20 UNDERTAKER ADDRESS

APR 19 1929

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

5-1

UNIVERSITY OF MARYLAND

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45199

CERTIFICATE OF DEATH.

E 45199

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Bay City Hospital St. 76-37 Ward)

2-FULL NAME Unknown

(a) RESIDENCE NO. Centreville ? St._____ Ward_____

(Usual place of abode)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: unknown

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
about 35				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Common

(c) Name of employer

9 BIRTHPLACE (city or town): Centreville

(State or country): Md

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country): unknown

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): unknown

14 Informant: unknown

(Address): unknown

Filed APR 19 1929 HARRY JOHNS, M.D.

3400 By Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4 19 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows: Acute Alcoholism

(duration) E yrs. ___ mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) ___ yrs. ___ mos. ___ ds.

(Signed) James H. Hutton M. D. (Coroner)

4/17 1929 (Address) 702 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ___ yrs., 1 mos., 12 ds. In the State ___ yrs., ___ mos., ___ ds.

Where was disease contracted, if not at place of death? Gratt St

Former or usual residence Centreville

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Date of Burial 19

20 UNDERTAKER: ADDRESS

APR 19 1929

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

UNIVERSITY OF MARYLAND

Commissioner Health.

STATE MORGUE

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45200

100-001

E 45200

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST., WARD)

2—FULL NAME Mary Helfrich

(a) RESIDENCE NO. 160 Gladstone ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) Own

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Jas. Helfrich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Cath Schumpeff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Jennie Baum

(Address) 1624 Lamont ave

15 Filed ..., 19 C. HAMPSON JONES, M. D.

R 191929 Registrar Hall

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/12/29

17 I HEREBY CERTIFY, That I attended deceased from 4/11, 19 29, to 4/12, 19 29, that I last saw h[illegible] alive on 4/12, 19 29 and that death occurred, on the date stated above, at 11.4 m.

The CAUSE OF DEATH* was as follows: Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Fatal

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) H. M. Hall M. D.

, 19 (Address) Balt City Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cemetery	April 20 1929.
20 UNDERTAKER	ADDRESS
Geo. F. Rust	1735 Harford ave

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45201

CERTIFICATE OF DEATH

166

E 45201

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Balt City Hospital St., 24-23 Ward)

2-FULL NAME Mary Hunt

(a) RESIDENCE NO. 703 Harvey St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Henry Hunt

6 DATE OF BIRTH (month, day, and year) Jan 20 1897

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
32	2	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife 37
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Virginia.

PARENTS

10 NAME OF FATHER William Slater

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Addie Schooler

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

14 Informant Henry Hunt
(Address) 703 Harvey St

15 Filed 4-19-1929 C. HAMPSON JONES M.D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) August 18 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bulbard Hg. T lab
Cat Poisoning Suicide
Probly Insane

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? no Date of

Was there an autopsy? Yes

What test confirmed diagnosis? See 17

(Signed) James M Fenton M. D.

4 16 1929 (Address) 700 Chase E

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem	4-22 1929
20 UNDERTAKER	ADDRESS
Ed B Nash 115	E Ussell

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45202

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 V E 45202

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2420 Orleans ST. 6-10 WARD)

BREITSCHWERDT

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Geo. J. Breitschwerdt.

(a) RESIDENCE NO. 2420 Orleans. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary. Breitschwerdt

6 DATE OF BIRTH (month, day, and year) March 4 1865

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
64	0	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman

(b) General nature of industry, business, or establishment in which employed (or employer) Copper Works.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Mary Breitschwerdt

(Address) 2420 Orleans St

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-17-29

17 I HEREBY CERTIFY, That I attended deceased from March 16, 1929, to Apr 17, 1929, that I last saw h— alive on Apr 17 L. 1929 and that death occurred, on the date stated above, at 5 30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial nephritis

(duration) One yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Warren F. Grems, M. D.

Apr. 19, 1929 (Address) 1400 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	4-20th 1929

20 UNDERTAKER Bernard C. Harle ADDRESS 1000 S. Paca St.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45203

CERTIFICATE OF DEATH

129

E 45203

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 824 N. Washington ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rudolph Oleska

(a) RESIDENCE NO. 824 N. Washington ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. 1 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Ella Oleska

6 DATE OF BIRTH (month, day, and year) April 16 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40		7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Oleska

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Rose Kopulecky

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Ella Oleska

(Address) 824 N. Washington St.

15 Filed C. HAROLD JONES, M. D.
Registrar

R 15182

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18 1929

17 I HEREBY CERTIFY, That I attended deceased from Mar. 28, 1929, to April 18, 1929, that I last saw him alive on April 18, 1929, and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

Chronic Interstitial Nephritis

(duration) 4 yrs. mos 20 ds.

CONTRIBUTORY (Secondary) Acute Nephritis

Pneumonia (duration) yrs. mos 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical degrees

(Signed) Theodore Oleska, M. D.

, 19 (Address) 824 N. Wash. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	July 22 1929

20 UNDERTAKER Knust & Crook & Son ADDRESS 1906 Eastlavde

Spec.—2-29-28—L. F. S.—500 Bks.

E 45204 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49 E 45204

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 914 Chauncy ave ST., 13-59 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Barney Nicholsen (Nicholson)

(a) RESIDENCE NO. 914 Chauncy ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if foreign birth 24 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	white	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Moses Nicholsen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Leah Nicholsen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant M. A. Harris

(Address) 914 Chauncy ave

15 Filed APR 19 1929 G. H. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/18/29

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1928, to Apr 18, 1929, that I last saw h[illegible] alive on Apr 18 1929 and that death occurred, on the date stated above, at 6.30 P m.

The CAUSE OF DEATH* was as follows:

Tumor of Brain

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas. F. Blake, M. D.

Apr 19 1929 (Address) 20 E Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Norfolk Va

DATE OF BURIAL 4/19 1929

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E Baltimore St

Spec.—2-29-28—L. F. S.—500 Bks.

E 45205

HEALTH DEPARTMENT—CITY OF BALTIMORE

Dr Phillips
2300 Edmondson Ave
41 E 45205

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 785 Carroll ST. 21-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Glendenning

(a) RESIDENCE NO. 785 Carroll ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, ~~Married~~, Widowed, or Divorced, (write the word): Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of: Dora Glendenning

6 DATE OF BIRTH (month, day, and year): May 3rd 67

7 AGE: 66 Years | Months: 11 | Days: 13 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Underware Factory

(b) General nature of industry, business, or establishment in which employed (or employer): Making Underwear

(c) Name of employer: Erlingers Factory

9 BIRTHPLACE (city or town). (State or country): England

PARENTS

10 NAME OF FATHER: William Glendenning

11 BIRTHPLACE OF FATHER (city or town). (State or country): England

12 MAIDEN NAME OF MOTHER: Mary Brown

13 BIRTHPLACE OF MOTHER (city or town). (State or country): England

14 Informant: Dora Glendenning

(Address): 785 Carroll St

15 Filed: , 19 C. HAMPSON JONES, M.D. Registrar

19 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 18-1929 H.B.

17 I HEREBY CERTIFY, That I attended deceased from April 13, 1929, to April 18, 1929, that I last saw h- alive on April 18, 1929 and that death occurred, on the date stated above, at 4.30 a m.

The CAUSE OF DEATH* was as follows: Septic Infection of Post nasal tissue extending over mouth & face & chest.

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary): none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Microscopic examination

(Signed) Chas H. Phillips, M. D.

, 19 (Address) 2300 Edmondson ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem

DATE OF BURIAL: April 19

20 UNDERTAKER: William Cook

ADDRESS: 1217 St Paul St Balto md

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 45206

REGISTERED NO. 129 E 45206

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 11-25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Logan

(a) RESIDENCE NO. Maryland Hotel St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 23 - 1860

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
	69	1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hotel Employee

(b) General nature of industry, business, or establishment in which employed (or employer) Md Rainy and Clerk

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph Logan

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Horace L. Dushane

(Address) 32 West 26th Street

R 197929 C. HAMPSON JONES, Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/18/29 19

17 I HEREBY CERTIFY, That I attended deceased from 4/18/29, 19..., to 4/18/29, 19...,

that I last saw h/ M alive on 4/18/29, 19...,

and that death occurred, on the date stated above, at 8 35 P.M. m.

The CAUSE OF DEATH* was as follows:

Cardio Vascular Renal Disease

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Heart Disease

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Jos. Umstead M. D.

. 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery — Date of Burial 4/20 1929

20 UNDERTAKER Williams Cook — ADDRESS 1217 St Paul

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45207 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH X 132 E 45207

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Univ Hosp 4th ST. 430 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME August Greenberg

(a) RESIDENCE NO. Walnut Ave & Belair Rd ST., WARD Balto Co, Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. 6 How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Greenberg

6 DATE OF BIRTH (month, day, and year) Aug 24 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45	6	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Iron Worker. 099

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Karl Greenberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Hatchott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Geo. Koerner

(Address) 2942 E. Monument St.

15 C. HAMPSON JONES, M. D. Registrar

R 191929 Bur. BCA

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/17/29.

17 I HEREBY CERTIFY, That I attended deceased from 4/6/, 1929, to 4/17/, 1929.

that I last saw h.. alive on 4/17/, 1929

and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Toxic Delirium

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Renal & Bladder Calculi,

Epilepsy (duration) 2? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? No. "Acute Encephalitis"

(Signed) E. F. Linthicum, M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Redemption DATE OF BURIAL 4/20 1929

20 UNDERTAKER J J Moran ADDRESS E Balto.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45208

CERTIFICATE OF DEATH

90 E 45208

1—PLACE OF DEATH

REGISTERED NO. 2324

CITY OF BALTIMORE: (No. 1830 Light St. ST. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie Bowinkelman

(a) RESIDENCE NO. 1830 Light St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 69 yrs. 6 mos. 16 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Theodore Bowinkelman

6 DATE OF BIRTH (month, day, and year) Oct 2 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	6	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md. (State or country)

PARENTS

10 NAME OF FATHER Andrew Clements

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Mrs. Keagle

(Address) 1830 Light St

15 Filed 19 C. HAMPSON JONES M. D. Registrar

R 101029

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-18-29

17 I HEREBY CERTIFY, That I attended deceased from Apr 1, 19 29, to Apr 18, 19 29.

that I last saw h[illegible] alive on Apr 17, 19 29

and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) E. F. Lewis M. D.

4-19 19 29 (Address) 1 E Randall Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	4-21 19 29
20 UNDERTAKER J. Fenw. McCully	ADDRESS 1308 Fort

Spec.—2-29-28—L. F. S.—500 Bks.

E 45209 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 45209

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE: (No. 26-31 ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Zolkow

(a) RESIDENCE NO. 1114 S. Bouldin ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor shop

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Records of BALTIMORE CITY HOSPITALS
(Address)

15 Date APR 19 1929, 19 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 17, 19 29 to April 18, 19 29

that I last saw him alive on April 18, 19 29

and that death occurred, on the date stated above, at 4:45 P m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis
myocardial insufficiency
(History not available)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) General anemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) H. M. Hurst M. D.

19 (Address)

*State the **Disease Causing Death**, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ukr Russian People Independent Orth Ch Holy Trinity	April 20 1929
20 UNDERTAKER	ADDRESS
Stephen J. Fialkowski Inc	1000 S. Kenwood ave

Spec.—2-29-28—L. F. S.—500 Bks.

E 45210

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 45210

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1021 Brentwood Ave ST. 10-15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Michael Barrett

(a) RESIDENCE No. 1021 Brentwood Ave ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Barrett

6 DATE OF BIRTH (month, day, and year) Feb. 1, 1864

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
65	2	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) City

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Texas, Md.

PARENTS

10 NAME OF FATHER James Barrett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Gavin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Miss Nora Barrett
(Address) 1021 Brentwood Ave

15 [illegible] C. HAMPSON JONES, M. D.
191929 Per [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 17 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 22 , 1929 to Apr 17 , 1929, that I last saw him alive on Apr 16 , 1929 and that death occurred, on the date stated above, at 4A m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Asthenia

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) L. M. C. Parker M. D.

7/16, 1929 (Address) 1114 Hollins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Texas, Md

DATE OF BURIAL Apr. 20 1929.

20 UNDERTAKER Rida Mitchell & Grumbine

ADDRESS

Spec.—1-12-23—M&T—500 Blks.

E 45211 HEALTH DEPARTMENT—CITY OF BALTIMORE E 45211

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor St. 10-14 WARD) 90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cornelius Mc Garitty

(a) RESIDENCE NO. Paston + Valley ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER James Mc Garitty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen Reilly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Little Sisters of the Poor (Address) Paston + Valley St

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18 1929

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1929, to April 18, 1929, that I last saw h alive on April 11, 1929, and that death occurred, on the date stated above, at 10 p m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D Bernard Wess M. D.

4/19, 1929 (Address) 1916 E Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters Cathedral DATE OF BURIAL Apr 20. 1929

20 UNDERTAKER Rita Wiedefeld ADDRESS 914 Gramt Av

TION is very important. See instructions on back of certificate.

R 191929

Spec. –7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 45212 ✓ × 84 E 45212

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 4-7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Montgomery

(a) RESIDENCE NO. 28 E 7th St Frederick Md. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 12 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	abt × 76			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bread Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 066

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Lord Montgomery

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Crawford

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Mrs. Susan Montgomery

(Address) 28 E. 7th St. Frederick Md.

15 Filed C. HAMPSON JONES, M. D. Registrar

By

R 191929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/19/29.

17 I HEREBY CERTIFY, That I attended deceased from 4/7/29, 19..... to 4/19/29, 19.....,

that I last saw h/ M. alive on 4/19/29, 19.....,

and that death occurred, on the date stated above, at 9 a.m. m.

The CAUSE OF DEATH* was as follows:

Cerebral Tumor – Glioma

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? yes Date of 4/13/29

Was there an autopsy?

What test confirmed diagnosis? Operation

(Signed) J. S. Winstead, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem. Frederick

Date of Burial April 21 1929

20 UNDERTAKER H. M. Dwyer

ADDRESS Mt. Airy

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 24521 3

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 45213

REGISTERED NO.

1—PLACE OF DEATH ...HNS HOPKINS HOSPITAL

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ... ST 7-9 ... WARD)

2—FULL NAME Nettie Curry

(a) RESIDENCE NO. 1609 S. Washington St WARD Wash. Co.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. 13 ds. How long in U. S., if foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ...ember 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER Wm Arnold

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md -

12 MAIDEN NAME OF MOTHER Mary Hallcroft

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

14 Informant Reads -

(Address) JOHNS HOPKINS HOSPITAL

15 Date received APR 19 1929 C. RAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19-29

17 I HEREBY CERTIFY, That I attended deceased from April 6 ... 1929 ... to April 19 ... 1929 ... that I last saw her alive on April 19 ... 1929 and that death occurred, on the date stated above, at 12 40 P m.

The CAUSE OF DEATH* was as follows:

(a) Pneumonia, lobar

Contributory ... (duration) ... yrs. ... mos. ... ds.

(Secondary) Empyema, both lungs (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? Yes

What test confirmed diagnosis? ...

(Signed) C D Brice, M. D.

... 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Washington D. C.	Apr. 19 1929
20 UNDERTAKER Wm. R. G. Elliott	ADDRESS 1725 Ashland Ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45214

CERTIFICATE OF DEATH

74-001

E 45214

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore. (No. Fell Lowell Hill & McMechen St., Ward)

2-FULL NAME Thos Joyce.

(a) RESIDENCE NO. 1621 Madison Ave. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col.

5 Single, Married, Widowed or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary

6 DATE OF BIRTH (month, day, and year): 1905

7 AGE: Years 24 | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town): Balto
(State or country): Md.

PARENTS

10 NAME OF FATHER: Christopher Joyce

11 BIRTHPLACE OF FATHER (city or town): Balto
(State or country): Md.

12 MAIDEN NAME OF MOTHER: Mary J. Chapman

13 BIRTHPLACE OF MOTHER (city or town): Balto
(State or country): Md.

14 Informant: Mary J. Joyce
(Address): 505 Hanover St

15 Filed ..... 19.. C. HAMPSON JONES, ... Registrar

191929 Per ..... Clerk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): Apr 17th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to ..... death (Inquest, autopsy or inquiry) on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(Morbid Changes) (duration) ..... yrs. Sudden

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted? If not at place of death, give address: Fell Lowell Hill & McMechen Sts

Did an operation precede death? ..... Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Regular

(Signed) ..... M. D.

Apr 19 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dolan Wesley Cem

DATE OF BURIAL: 4-1929

20 UNDERTAKER: Daniel Taylor Co

ADDRESS 956

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45215

CERTIFICATE OF DEATH.

90 E 45215

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2413 Barkley St. 12-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Annie H. Jones

(a) RESIDENCE NO. 2413 Barkley St. 12 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jane F. Jones

6 DATE OF BIRTH (month, day, and year): Feb 7 1840

7 AGE — Years: 88 Months: 11 Days: 11 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Md

(State or country)

PARENTS

10 NAME OF FATHER: J. Worley

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Frankinger

12 MAIDEN NAME OF MOTHER: Frankinger

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Md

14 Informant: Edward B. Turner

(Address) 2463 Barkley St

15 C. HARRISON Jr. M.D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/17 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) John Morrison (Coroner) M. D.

4/17 1929 (Address) 3632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel Date of Burial 4/19 1929

20 UNDERTAKER: H. H. Cohn ADDRESS 2107 Gwynn

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

191929

Spec.—2-29-28—L. F. S.—500 Blks.

Dr Wemstock, 713 Augusta St

E 45216

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 45216

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 512 Archer ST. 21-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harry E Wilson Jr

(a) RESIDENCE NO. 512 Archer ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Agnes Wilson

6 DATE OF BIRTH (month, day, and year) Nov 20. 1899

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
29	11	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sprayer 086

(b) General nature of industry, business, or establishment in which employed (or employer) Paint Co

(c) Name of employer E Eichman

9 BIRTHPLACE (City or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Harry E Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Emma Scott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mrs Agnes Wilson

(Address) 512 Archer St

15 Filed ..... 19 ..... Registrar

R 191929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 9. 1929

17 I HEREBY CERTIFY, That I attended deceased from March 15th, 1929, to April 9, 1929, that I last saw h(im) alive on April 10th, 1929 and that death occurred, on the date stated above, at 3:00 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Alex A Wemstock M. D.

4/19, 1929 (Address) 713 Augusta ST

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Loudon Park

DATE OF BURIAL 4 23 1929

20 UNDERTAKER J. H. Cook

ADDRESS 2174 Eutaw

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45217

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45217

CERTIFICATE OF DEATH

74-09

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1631 Laurens ST. 16-23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Levi Sydnor

(a) RESIDENCE NO. 1631 Laurens ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Colored	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Josephine Sydnor

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) United Railway.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Charlotte Co Va

PARENTS

10 NAME OF FATHER Ezekiel Sydnor.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Rosa Phelps

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mazeine. Sorrell

(Address) 1639 Laurens St

15 Filed ... 19 ... C. HAMPSON JONES M. D. Registrar

R 19129 Per ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/17-24

17 I HEREBY CERTIFY, That I attended deceased from 4/13, 1924, to 4/17, 1924, that I last saw h[im] alive on 4/16, 1924, and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. ... mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) B. H. Stafford, M. D.

4/20 1924 (Address) 1715 Pennsylvania Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn cemetery — DATE OF BURIAL: April 19 1924

20 UNDERTAKER: Thomas. E. Kelson — ADDRESS: 503 Preston St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45218

CERTIFICATE OF DEATH.

17 E 45218

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1614 Lorman ST. 15-21 WARD)

2-FULL NAME Geraldine Ridgley

(a) RESIDENCE NO. 1614 Lorman ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 1 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	7	7	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School. old

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Philip Ridgley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Eliza Dorsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Philip Ridgley

(Address) 1614 Lorman St.

15 Filed C. HAMPSON JONES, M. D., Registrar

191929 By —

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Ap. 18 1929.

17 I HEREBY CERTIFY, That I attended deceased from Ap 8, 1929, to Ap 18, 1929, that I last saw h alive on " 17, 1929 and that death occurred, on the date stated above, at 5.45 P m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) — yrs. — mos 10 ds. old

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Urinary ele-

(Signed) Chas. C. Conser, M. D.

4/19, 1929 (Address) 1101 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn cemetery — DATE OF BURIAL April 22 1929

20 UNDERTAKER Thomas E. Kelson — ADDRESS 1303 Pierpont St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45219

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 45219

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1535 Lancaster ST., 3-5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jerry J. Kerner

(a) RESIDENCE NO. 1535 Lancaster ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Josephine Kerner

6 DATE OF BIRTH (month, day, and year) June 20 1858

7 AGE Years	Months	Days	If LESS than 1 day,....hrs. or.....min.
70.	9	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Printer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Penna. Paper Mfg. Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Nicholas Kerner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna M. Bayer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Jerry J. Kerner
(Address) 1535 Lancaster St.

15 Filed 191929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-17-29

17 I HEREBY CERTIFY, That I attended deceased from 3-3-, 1929, to 4-17-, 1929, that I last saw him alive on 4-17-, 1929 and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Cardio-renal disease

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) " " "

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Physical & Palmate. Test.

(Signed) Leo J. Kelly M. D.

4-19, 1929 (Address) 1937 Gough

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	April 20 1929
20 UNDERTAKER	ADDRESS
Kendall & Lippel	300 S Eden St

Spec.—1-12-23—M&T—500 Blks.

E 45220 HEALTH DEPARTMENT—CITY OF BALTIMORE B 45220

CERTIFICATE OF DEATH

161-001

REGISTERED NO.

1-PLACE OF DEATH Provident Hospital

CITY OF BALTIMORE: (No. 1514 Division St. 14-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Betty Lee Alexander

(a) RESIDENCE NO. 1611 McCulloh ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: infant

6 DATE OF BIRTH (month, day, and year): Dec 2, 1928

7 AGE: Years — Months: 4 — Days: 15 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balt. Md.

PARENTS

10 NAME OF FATHER: Ed. Alexander.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ga.

12 MAIDEN NAME OF MOTHER: Mary Towers

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. C.

14 Informant: Mother

(Address)

15 Filed ... 19 ... Registrar

C. HAMPSON DORSEY, M.D.

R 20 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 17 1929

17 I HEREBY CERTIFY, That I attended deceased from March 8, 1929, to April 17, 1929.

that I last saw her alive on April 17, 1929,

and that death occurred, on the date stated above, at 9 5/4 A m.

The CAUSE OF DEATH* was as follows: —

(a) Pyloric Stenosis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Prematurity

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) W. H. Butler, M. D.

(Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn

DATE OF BURIAL: 4/20/1929

20 UNDERTAKER: Mrs. Geo. H. Holland

ADDRESS: 1631 Druid Hill

TION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45221

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

24-001

E 45221

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 1017 S. Clinton ST., 26-1 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Fredericka Kiefer

(a) RESIDENCE NO. 1017 S. Clinton ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Kiefer

6 DATE OF BIRTH (month, day, and year) July 23-1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	8	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Zacharis Helm

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Louisa Hahn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Ella Williams

(Address) 1017 S. Clinton St.

15 Filed ..... 19 .....

Registrar

R201929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April-18-1929

17 I HEREBY CERTIFY, That I attended deceased from Apr 13, 1929, to Apr 18, 1929, that I last saw h w alive on Apr 18, 1929 and that death occurred, on the date stated above, at 11 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Aorta pulmonary oedema

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Albert Haber, M. D.

4/19, 1929 (Address) Maplewood - Belair Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery

DATE OF BURIAL April 21, 1929

20 UNDERTAKER George W. Zickler

ADDRESS 1737 E. Eager St

Spec.—2-29-28—L. F. S.—500 Bks.

2E 45222

HEALTH DEPARTMENT—CITY OF BALTIMORE

40 E 45222

CERTIFICATE OF DEATH

1—PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST. 3-4 WARD) REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Kitrell

(a) RESIDENCE NO. 126 S Caroline ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: black

5 Single, Married, Widowed, or Divorced, (write the word): Single

6 DATE OF BIRTH (month, day, and year) 11-30-03

7 AGE — Years: 25 | Months: 4 | Days: 17 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Chemist

(b) General nature of industry, business, or establishment in which employed (or employer): Chemical factory

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER Abraham Kitrell

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C

12 MAIDEN NAME OF MOTHER Ella Blunt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N C

14 Informant Friends
(Address) JOHNS HOPKINS HOSPITAL

15 Filed 201929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17-1929

17 I HEREBY CERTIFY, That I attended deceased from April 10. 1929 to April 17. 1929 that I last saw him alive on April 17. 1929 and that death occurred, on the date stated above, at 4 a m.

The CAUSE OF DEATH* was as follows:

Acute Interstitial Endocarditis
(Coronary)

(duration) yrs. 1/2 mos. ds.

CONTRIBUTORY (Secondary)
Chronic Pancreatitis (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Yes

(Signed) C O Briggs, M. D.

. 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: asbury cemetery — DATE OF BURIAL: april 20 1929

20 UNDERTAKER: Edward Bryan — ADDRESS: 1631 orleans st

Spec.—2-29-28—L. F. S.—500 Blks.

E 45224 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 45223

1—PLACE OF DEATH

REGISTERED NO. 70-69

CITY OF BALTIMORE: (No. 129 S. Calverton Rd. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James J. Curreid

(a) RESIDENCE NO. 129 S. Calverton Rd. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) [redacted] Barbara Curreid

6 DATE OF BIRTH (month, day, and year) March 6 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shipwright Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER John Curreid

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Brennan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Barbara Curreid
(Address) 129 S. Calverton Rd

15 Filed [illegible], 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/1/29

17 I HEREBY CERTIFY, That I attended deceased from Apr 29, 1928, to Apr 1, 1929, that I last saw h[illegible] alive on 4/1/29, 19, and that death occurred, on the date stated above, at 3 25 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis
Chronic Diffuse Nephritis
Hypertension

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Bernard J. Terry, M. D.

4/1/1929 (Address) 910 W. Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	Apr 22 1929
20 UNDERTAKER Charles H. Kechner	ADDRESS 1032 Hollins

Spec.—2-29-28—L. F. S.—500 Bks.

E 45225 HEALTH DEPARTMENT—CITY OF BALTIMORE E 45224

CERTIFICATE OF DEATH

90

1—PLACE OF DEATH

REGISTERED NO. 90

CITY OF BALTIMORE: (No. 1314 Webster ST. 24-32 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Barbara Will

(a) RESIDENCE NO. 1314 Webster ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Will

6 DATE OF BIRTH (month, day, and year): Mar. 4, 1853

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
76	1	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Leonard Hammerbacher

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Catherine Kuhn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Henry Will

(Address) 1314 Webster St

15 [illegible] 20 1929 C. THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4.17.29.

17 I HEREBY CERTIFY, That I attended deceased from about 1919, 19..., to 4.17.29, 19...,

that I last saw her alive on 4.17.29, 19...

and that death occurred, on the date stated above, at 1.45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary): Bronchitis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Philip B. Towles, M. D.

4.17.29. 19 (Address) 1432 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery | DATE OF BURIAL: Apr. 20, 29

20 UNDERTAKER: Margaret J. Flynn | ADDRESS: 1402 Light St.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45226

CERTIFICATE OF DEATH

57 E 45225

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 319 N. Madison St. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Betty Siebert

(a) RESIDENCE NO. 319 N. Madison St., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of John C. Siebert

6 DATE OF BIRTH (month, day, and year) July 11-1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	9	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER John Lober

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Mary Markolf

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Mrs Mary Siebert

(Address) 319 N. Madison St

15 201929 C. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 18-1929

17 I HEREBY CERTIFY, That I attended deceased from 1/1/29, 19..., to Apr 18, 1929 that I last saw h alive on Apr 17 30, 1929 and that death occurred, on the date stated above, at 2 AM m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes Coma (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. H. Campbell, M. D.

4/18, 1929 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	Apr 20 1929
20 UNDERTAKER Wm J Tucker & Sons	ADDRESS N. Y Pa

Spec.—1-12-23—M&T—500 Bks.

E 45226 HEALTH DEPARTMENT—CITY OF BALTIMORE E 45226

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2911 E (St.) Baltimore (Ward) 6-11

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William E. Klepper.

(a) RESIDENCE No. 2911 E. Baltimore ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Dec. 30. 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	44	3	17.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer): Emmerson Drug Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Chas. F. Klepper

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Anna S. Lidig

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Anna A. Klepper. (Address) 2911 E. Baltimore St

15 G. HAMPSON JONES, M. D. Registrar

R 201929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 18 1929

17 I HEREBY CERTIFY, That I attended deceased from April 17 1929, to April 18 1929, that I last saw h[illegible] alive April 18 1929, and that death occurred, on the date stated above, at 11:45 [illegible] m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage,

Hemiplegia

yrs. 1 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. Knox Insley, M. D.

(Address) H. Knox Insley

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	April 22 1929

20 UNDERTAKER: Mrs. Mrs. John H. Tenser & Son ADDRESS: 74 N. Fayette

TION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45227

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001 E 45227

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) ST., (WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Leo Wheesse

(a) RESIDENCE NO. 502 Light ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
23				

8 OCCUPATION OF DEACESED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) ?
(State or country) Va.

PARENTS

10 NAME OF FATHER Fred. L. Wheesse

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) Va.

12 MAIDEN NAME OF MOTHER Theresa ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) Va.

14 Informant Records
(Address) BALTIMORE CITY HOSPITALS

15 Filed 4-20, 1929 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-14-29

17 I HEREBY CERTIFY, That I attended deceased from 4-10, 1929, to 4-14, 1929, that I last saw h[illegible] alive on 4-14, 1929 and that death occurred, on the date stated above, at 9.50 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia, T.T.

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Myocarditis, Chronic

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Typical Clin. Picture

(Signed) Harold W. McLean, M. D.

4-14, 1929 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart — DATE OF BURIAL 4/20/29

20 UNDERTAKER John J. Thompson — ADDRESS 1318 Light

Spec.—2-29-28—L. F. S.—500 Blks.

E 45228

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

05 E 45228

1—PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Nathan Frank

(a) RESIDENCE NO. Newbern N. C. ST.. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 mos. 15 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Betty

6 DATE OF BIRTH (month, day, and year) Mar. 16th 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	64	1	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waste Materials

(b) General nature of industry, business, or establishment in which employed (or employer) Dealer.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Philip Frank.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Dora Friedman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia.

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 R201929 ..... 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19-1929

17 I HEREBY CERTIFY, That I attended deceased from Feb 11 . 1929. to April 19. 1929

that I last saw him alive on April 19 . 1929

and that death occurred, on the date stated above, at 7:30 m.

The CAUSE OF DEATH* was as follows:

Pyelonephritis

Uremia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Benign Prostatic Hypertrophy (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? yes Date of 3/16/29

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. Cosmith, M. D.

. 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Newbern N. C.

DATE OF BURIAL April 20 29

20 UNDERTAKER Chas. G. Black.

ADDRESS 742 W. North

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E. 45229

CERTIFICATE OF DEATH.

90 E 45229

REGISTERED NO._____

1-PLACE OF DEATH In decorating Co

City of BALTIMORE: (No. 2805 Hood Foster St. 13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Howard P. Meyers

(a) RESIDENCE NO. 1106 S Kinwood St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clara Meyers

6 DATE OF BIRTH (month, day, and year) Aug. 5 1878

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	51	8	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Press operator

(b) General nature of industry, business, or establishment in which employed (or employer) Operator

(c) Name of employer Lee Decorator

9 BIRTHPLACE (city or town)_____

(State or country) Salt Lake City

PARENTS

10 NAME OF FATHER Wm. F. Meyers

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) Salt Lake City

12 MAIDEN NAME OF MOTHER Mary Lutz

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) Germany

14 Informant Lee B. Meyers

(Address) 527 S. Bl[illegible]

15 Filed_____, 19____ HAMPSON JONES, M.D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension

20 yrs (duration) yrs. mos. ds.

(Signed) [signature] M. D.

(Coroner)

4/19 1929 (Address) 705 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the state.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?_____

Former or usual residence_____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery Date of Burial 4/22 1929

20 UNDERTAKER L. G. Moran ADDRESS 3008 E Balto

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

R201929

Spec.—2-29-28—L. F. S.—500 Bks.

E 45230

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 111-002 E 45230

REGISTERED NO.

1—PLACE OF DEATH JOHNS HOPKINS HOSPITAL

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST. 7-4 WARD)

2—FULL NAME Dr Arthur S. Loevenhart

(a) RESIDENCE NO. 40 Roby Road ST. WARD
(Usual place of abode) Madison Wisconsin

Length of residence in city or town where death occurred yrs. mos. 2s ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W	married

a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician

(b) General nature of industry, business, or establishment in which employed (or employer) Univ. of Wisconsin

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kentucky

PARENTS

10 NAME OF FATHER Henry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Jennie Goldsmith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20-1929

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1929, to April 20, 1929, that I last saw h[illegible] alive on April 20, 1929 and that death occurred, on the date stated above, at 2 A.m.

The CAUSE OF DEATH* was as follows:

Peritonitis following operation for gastro-jejunal ulcer-

since July 1928
(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of April 12, 1929

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) Fred W. Keil, M. D.

. 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	Apr 20 19 29
20 UNDERTAKER	ADDRESS
John O Mitchell Son	1900 Eutaw Pl

Spec.—2-29-28—L. F. S.—500 Bks.

Dr Campbell Hyde Hanover St

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45231

CERTIFICATE OF DEATH

74-001

REGISTERED NO. E 45231

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1 North Stricker ST. 19-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harry L. Stern

(a) RESIDENCE NO. 1 N Stricker ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred / yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Hattie Stern

6 DATE OF BIRTH (month, day, and year) Sept. 3. 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	7	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER George Stern

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Anne M. Stultz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Hattie Stern

(Address) 1 N Stricker St

15 Filed 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 18, 1929 to April 19, 1929

that I last saw h alive on April 19, 1929

and that death occurred, on the date stated above, at 11-10 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. L. K. Campbell, M. D.

4/20, 1929 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pine Lawn MD	4/22 19 29
20 UNDERTAKER	ADDRESS
H. Cook	2124 Pine St

Spec.—2-29-28—L. F. S.—500 Bks.

Dr Duncan 5106 York Rd

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45232

CERTIFICATE OF DEATH

Govan 74-001

E 45232

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 400 Lyman Ave ST., 27-46 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ellen Agnes MacFarlane

(a) RESIDENCE NO. 400 Lyman Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6 DATE OF BIRTH (month, day, and year): May 12, 1860

7 AGE: Years 68 Months 11 Days 4 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: At Home

9 BIRTHPLACE (city or town) (State or country): New York

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Anne Kiernon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Edith A. MacFarlane

(Address) 400 Lyman Ave

15 Filed PR21328 HAMPDEN JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr. 19, 1929

17 I HEREBY CERTIFY, That I attended deceased from Apr 7 1929 to Apr 19, 1929, that I last saw her alive on Apr 19, 1929 and that death occurred, on the date stated above, at 8 1 m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary): Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E. M. Duncan, M. D.

Apr 20, 1929 (Address) 5106 York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Linn Cook, Md

DATE OF BURIAL: 4/22 1929

20 UNDERTAKER: J. H. Cook

ADDRESS: 1217 Linden St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

38

E 45233 — CERTIFICATE OF DEATH — E 45233

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS — REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 16-22 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ida McClure

(a) RESIDENCE NO. 1149 N. Fulton Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: J. C. Miner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Connecticut

12 MAIDEN NAME OF MOTHER: Sarah ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Delaware

14 Informant: Records of BALTIMORE CITY HOSPITALS
(Address)

15 Date Received APR 21 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 20, 1929

17 I HEREBY CERTIFY, That I attended deceased from January 4, 1928, to April 20, 1929, that I last saw her alive on April 20, 1929 and that death occurred, on the date stated above, at 12:15 A m.

The CAUSE OF DEATH* was as follows:

General Paresis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lues - terminal Bronchopneumonia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no Physical Exam. What test confirmed diagnosis?

(Signed) Marvin M. McClean, M. D.
, 19 (Address)

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	4-23 1929
20 UNDERTAKER W. M. Cook	ADDRESS 1217 E Fond St

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45234

CERTIFICATE OF DEATH.

90 E 45234

1-PLACE OF DEATH

City of BALTIMORE: (No. Franklin Square Hospital St. 19-29 Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Susan E. Elphring

(a) RESIDENCE NO. 1309 W. Lombard St. St._____ Ward_____

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Francis A. Elphring

6 DATE OF BIRTH (month, day, and year) July 8, 1856

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	72	9	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town)_____

(State or country) Maryland

PARENTS

10 NAME OF FATHER Ephrain Pearce

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Jones

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country) Md.

14 Informant Francis A. Elphring

(Address) 1309 W. Lombard St.

Filed APR 21 1929 Mary Jones, M. D. City Registrar

By Kelly

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/18 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) Chas. H. Brooke M. D.

(Coroner) 5107 Dunn Loring

4/5, 1927 (Address) Brooklyn Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem. Date of Burial 4/22 1929

20 UNDERTAKER Harry A. Wilkes ADDRESS 531 W. Lombard St.

OF DEATH In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45235

CERTIFICATE OF DEATH

90

REGISTERED NO. E 45235

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1825 N. Castle St. ST., 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles F. Snyder

(a) RESIDENCE NO. 1825 N. Castle St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Blanche A. Snyder (nee Ellis)

6 DATE OF BIRTH (month, day, and year) Aug. 29, 1875.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	7	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland.

PARENTS

10 NAME OF FATHER Justus W. Snyder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Maria Buchheit

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Blanche A. Snyder

(Address) 1825 N. Castle St.

15 Filed 4 19 29 C. McPHERSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-19-29

17 I HEREBY CERTIFY, That I attended deceased from 9-1, 1928, to 4-19, 1929 that I last saw him alive on 4-19, 1929 and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Myocardial disorder & degeneration

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) Odell Ruseld, M. D.

4/19, 1929 Address) 1500 Bolton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL 4/22/29

20 UNDERTAKER Harry N. Miller

ADDRESS 531 N. Howard St.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45236

CERTIFICATE OF DEATH

66

E 45236

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 87 E. Hughes St. St., 42-33 Ward)

2-FULL NAME Jessie J. Jackson. (C)

(a) RESIDENCE NO. 87 E. Hughes St. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Do not know.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	88	----------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Virginia

PARENTS

10 NAME OF FATHER George Jackson. (C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Olie Watson. (C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

14 Informant Broadus Thompson. (C)
(Address) 614 G St. N. E. Washington D. C.

15 Filed ..... 192... C. HAMPSON JONES, M. D. Registrar

R 21029

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 17, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? History

(Signed) [signature], M. D.

4/20. 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Superintendent Arlington National Cem. Fort Myer Va	4-22 1929
20 UNDERTAKER Worthington & Co. Daniel Easton	ADDRESS 916 Pa ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

Coulter

E 45237

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

131

E 45237

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Baltimore City Hospital ST., [illegible] WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Wm Coulter

(a) RESIDENCE NO. 403 S. Clement ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D C

PARENTS

10 NAME OF FATHER Wm Coulter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Rachael Neal

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Balto City Hosp

(Address)

15 Filed 2 1 1929 C. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/19/29

17 I HEREBY CERTIFY, That I attended deceased from 4/11, 1929, to 4/19, 1929, that I last saw h— alive on 4/19, 1929, and that death occurred, on the date stated above, at 3:45 m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

Acute

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of 4/13/29

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) T. Jr. Stack M. D.

, 19 (Address) Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 4-23 1929

20 UNDERTAKER Daniel Carter

ADDRESS 916 Eq Ave

Spec.—1-12-23—M&T—500 Blks.

E 45238

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

148 E 45238

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West Balto. Gen'l Hosp ST. 6-4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theresa Schweitzer

(a) RESIDENCE No. 220 N. Castle ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Schweitzer

6 DATE OF BIRTH (month, day, and year) Nov 17, 1907

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or ... min.
	21	5	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Morris Friedman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Betty Ordit

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Edward Schweitzer

(Address) 220 N. Castle St

Filed APR 21 1929 C. HAMPTON JOHNS, M. D. Registrar

Per [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20, 1929.

17

I HEREBY CERTIFY, That I attended deceased from Apr. 10, 1929, to April 20th, 1929, that I last saw h[illegible] alive on April 20th, 1929 and that death occurred, on the date stated above, at 2·15 A m

The CAUSE OF DEATH* was as follows:

Toxemia of Pregnancy

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Pregnancy & Involution (duration) yrs. 3½ mos. ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? yes Date of Apr. 17

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jack J. Singer, M. D.

4/20 1929 (Address) West Balto. Gen'l Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Workmen Circle Cem DATE OF BURIAL 4/21 1929

20 UNDERTAKER Jack Lewis 1404 Edalo St ADDRESS

TION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

22E 3773 45239

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

32 V E 45239

1—PLACE OF DEATH ...NS HOPKINS HOSPITAL

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST. 3-4 WARD)

2—FULL NAME Nathan Cohen

(a) RESIDENCE NO. 1411 E. Balto. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ...6... yrs. 3 mo. ds. How long in U. S., if foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) 1925

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
4	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Buffalo (State or country) N. York

PARENTS

10 NAME OF FATHER Joseph

11 BIRTHPLACE OF FATHER (city or town) Poland (State or country)

12 MAIDEN NAME OF MOTHER Rose Kennell

13 BIRTHPLACE OF MOTHER (city or town) Austria (State or country)

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 2 1 1929 HAMPSON JONES, M. D.

By ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19-1929

17 I HEREBY CERTIFY, That I attended deceased from April 14, 1929, to April 19, 1929, that I last saw him alive on April 19, 1929, and that death occurred, on the date stated above, at 6.55 P m.

The CAUSE OF DEATH* was as follows:

Tuberculous meningitis

(duration) ... yrs. ... mos. 15 ds.

CONTRIBUTORY (Secondary) .....

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Lumbar puncture

(Signed) V. C. Jeans, M. D.

4, 19. 1929 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rehrer Nash Road

DATE OF BURIAL 4/21 1929

20 UNDERTAKER Jack Lewis

ADDRESS 1409 E Balto St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45240

CERTIFICATE OF DEATH

90 ✓ E 45240

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1508 E Hoffman ST., 8-17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank Krieger

(a) RESIDENCE NO. 1508 E Hoffman ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred ½ yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Florence Krieger

6 DATE OF BIRTH (month, day, and year) Oct 10th 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	6	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hanover Pa. Pennsylvania

PARENTS

10 NAME OF FATHER Anthony Krieger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Florence Krieger

(Address) 1508 E Hoffman st

15 Filed APR 21 1929, 19 H. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20th /29

17 I HEREBY CERTIFY, That I attended deceased from Jan 15th, 1929, to April 20th, 1929, that I last saw h.. alive on April 20th, 1929 and that death occurred, on the date stated above, at 4 15 A m.

The CAUSE OF DEATH* was as follows:

Chronic Valv Endocarditis

Contributory

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) J. Theodore Bruck M. D.

4/1, 1929 (Address) 1005 Clark Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery — DATE OF BURIAL Apr 23rd 1929

20 UNDERTAKER George Schilling & Sons — ADDRESS 1126 E Monument St

Cor.—10-10-29—A Co.—100 Bks.

E 45241

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

91-002

E 45241

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 811 N. Streeper St St., 7-11 Ward)

2-FULL NAME Anna Katherine Jessnitzer

(a) RESIDENCE NO. 811 N. Streeper St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth 43 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Paul H.M. Jessnitzer

6 DATE OF BIRTH (month, day, and year) Nov 18/1864

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	64	5	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Holzeim Wurrttenburg
(State or country) Germany

PARENTS

10 NAME OF FATHER Gottlieb Haensler

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Katherine Stadelmaier

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant John Jessnitzer
(Address) 5511 N. Plymouth Road Hamilton, Md.

15 Filed ..., 19... C. HAMPSON JONES, M.D. Registrar

APR 21 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 19/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

Hypertension-Arteriosclerosis

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? history

(Signed) J. H. Haller, M. D.

4/20/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL (Swartz) Cemetery 1st German Evangelical Congregation DATE OF BURIAL April 22 1929

20 UNDERTAKER Chas. J. Black ADDRESS 142 W. North ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45242

HEALTH DEPARTMENT—CITY OF BALTIMORE

118-002 E 45242

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 18-26

CITY OF BALTIMORE: (No. 543 N. Carrollton Ave. (Street) 18th (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lucy L. Cooper

(a) RESIDENCE NO. 543 N. Carrollton Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 14, 1866

7 AGE: Years 62 | Months 7 | Days 6 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Edinburg Va

PARENTS

10 NAME OF FATHER: George W. Cooper

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Drucilla Downey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Miss Mary Cooper

(Address) 543 N. Carrollton Ave

15 Filed APR 21 1929 C. H. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 20 1929

17 I HEREBY CERTIFY, That I attended deceased from Apr 4, 1929, to Apr 20, 1929, that I last saw h alive on Apr 19, 1929, and that death occurred, on the date stated above, at 8.15 a. m.

The CAUSE OF DEATH* was as follows:

Cellulitis left leg.

CONTRIBUTORY (Secondary) Paralytic ileus (duration) yrs. mos. 17 ds.

Septicemia (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Apr 12. 29

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo. Edmund Bowden, M. D.

4/29/1929 (Address) 1517 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Edinburg Va — DATE OF BURIAL: Apr 22 29

20 UNDERTAKER: W. J. Tickner & Sons — ADDRESS: North & Pa

Spec.—1-12-23—M&T—500 Blks.

E 45243

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 45243

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH West Baltimore General

CITY OF BALTIMORE: (No.) ST. 15-6 WARD)

2-FULL NAME Miss Maria L. Williams

(a) RESIDENCE NO. 3512 Clifton Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 5-1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	55	2	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H.W.

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Gloucester Co Va

PARENTS

10 NAME OF FATHER John W. Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Lottie Thornton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address)

15 C. HAMPSON JONES, M. D. Registrar

R 21 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/20, 1929

17 I HEREBY CERTIFY, That I attended deceased from 4/18, 1929, to 4/20, 1929, that I last saw h alive on 4/20, 1929 and that death occurred, on the date stated above, at 10:45 A.m

The CAUSE OF DEATH* was as follows:

Mediastinal Tumor

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. Hampson Jones M. D.

4/20, 1929 (Address) West Baltimore General.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Gloucester Co Va — DATE OF BURIAL April 22nd 1929

20 UNDERTAKER Leitch & Gore — ADDRESS 1723 W Lafayette Ave

TION is very important. See instructions on back of certificates.

Spec.--2-29-28—L. F. S.—500 Bks.

E 45244

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001 E 45244

CERTIFICATE OF DEATH

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE: (No. ..... ST., 3 E WARD) REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John P. Coughlan

(a) RESIDENCE NO. 137 S. Spring ST., 3 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown July 9, 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	9	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Maryland

PARENTS

10 NAME OF FATHER Patrick Coughlan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen Burnell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Records of

(Address)

15 Date received APR 21 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 15, 29, to April 19, 29, that I last saw him alive on April 19, 29, and that death occurred, on the date stated above, at 4:50 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage, I

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no What test confirmed diagnosis? Physical Exam

(Signed) Marvin M. Mc Cann M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	April 22nd 1929
20 UNDERTAKER	ADDRESS
Lilly & Zeiler Inc.	405 N. Howard St.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45245

CERTIFICATE OF DEATH

+ 117 ✓

E 45245

1—PLACE OF DEATH University Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. 4 ST. 30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emma Streit

(a) RESIDENCE NO. Corville Ave, ST., Halethorpe, Md WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., If foreign birth? 47 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 20, 1879

7 AGE 50 Years 49 Months 8 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labeler 086

(b) General nature of indastry, business, or establishment in which employed (or employer) Paint Factory

(c) Name of employer Hirschberg Paint Co

9 BIRTHPLACE (city or town) (State or country) Switzerland

PARENTS

10 NAME OF FATHER John Streit

11 BIRTHPLACE OF FATHER (city or town) (State or country) Switzerland

12 MAIDEN NAME OF MOTHER Elizabeth Ramseyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Switzerland

14 Informant Lena Streit Mangold

(Address) Corville Ave & Lime Rd

15 Filed APR 24 1929 HAMILTON JOHNS, M. D. Registrar

R 24 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20, 1929.

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1929, to April 20, 1929, that I last saw her alive on April 20, 1929, and that death occurred, on the date stated above, at 8.35 p.m.

The CAUSE OF DEATH* was as follows:

Coronary thrombosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Intra-abdominal abscess probably due to ruptured appendix (duration) yrs. 6 wks. ds.

18 Where was disease contracted If not at place of death? at home.

Did an operation precede death? No Date of 4/12/29

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) G. K. Gutak, M. D.

April 20, 1929 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery.	April 24 1929
20 UNDERTAKER Chas. W. Dill.	ADDRESS 3109 Fredk Ave.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45246

CERTIFICATE OF DEATH.

33

E 45246

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 703 Edmonson Ave (ST.) (WARD)

2-FULL NAME John T. Marbry

(a) RESIDENCE NO. 703 Edmonson Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	C	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 10 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	48	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington DC

PARENTS

10 NAME OF FATHER Anthony Marbry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Fairfax Va

12 MAIDEN NAME OF MOTHER Georgeanna Johnson

13 BIRTHPLACE OF MOTHER (city or town) Richmond (State or country) Va

14 Informant Mary Wheeler

(Address) 320 Florida Ave. NW

15 Filed ....., 19 Per ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 18 1929

17 I HEREBY CERTIFY, That I attended deceased from March 20, 1929, to Apr 18, 1929, that I last saw him alive on Apr 18, 1929, and that death occurred, on the date stated above, at 8.15 P m

The CAUSE OF DEATH* was as follows:

Tuberculosis of Intestines

(duration) yrs. 3 mos ? ds.

CONTRIBUTORY (Secondary) Cobor Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. McCoy, M. D.

4-20-1929 (Address) 1126 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Washington, D. C.	April 22 1929
20 UNDERTAKER	ADDRESS 322
Mrs. Katie R. Williams	4 Tehama Ave

'TION is very important. See instructions on back of certificates.

R 21 1929

WASHINGTON, D. C.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45247

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

CERTIFICATE OF DEATH

E 45247

1—PLACE OF DEATH

REGISTERED NO. .....

CITY OF BALTIMORE: (No. 738 Reservoir St. ST., 13-59 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Clarence Utley Kearfott

(a) RESIDENCE NO. 738 Reservoir ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 12 1907

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	21	3	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Student

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Joseph G Kearfott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Lillian A Chappel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

11 Informant Joseph G Kearfott

(Address) Brunswick Md

15 Filed APR 21 1929 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21-29

17 I HEREBY CERTIFY, That I attended deceased from April 13 - 1929 to April 21 1929, that I last saw h was alive on April 20th 1929, and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Chas L. Underhill, M. D.

4/21, 1929 (Address) 711 W Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Amherst Va

DATE OF BURIAL 4/22 1929

20 UNDERTAKER William Cook

ADDRESS 1212 St Paul

Spec.—2-29-28—L. F. S.—500 Bks.

E 44447
E 45248

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44 E 45248

REGISTERED NO.

1—PLACE OF DEATH JOHNS HOPKINS HOSPITAL

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 7-12 WARD)

2—FULL NAME Louise Svatora

(a) RESIDENCE NO. 2227 E Madison ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W.	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank

6 DATE OF BIRTH (month, day, and year): March

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: N.H. 07

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Bohemia

PARENTS

10 NAME OF FATHER: Joseph

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bohemia

12 MAIDEN NAME OF MOTHER: Louise Novak

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bohemia

14 Informant: Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed APR 22 1929, 19 ..... C. HARPSON JONES, M. D. Registrar.

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 21-1929

17

I HEREBY CERTIFY, That I attended deceased from April 16, 1929, to April 21, 1929, that I last saw her alive on April 21, 1929 and that death occurred, on the date stated above, at 4 45 P m.

The CAUSE OF DEATH* was as follows:

Primary Ca. of Stomach & Metastasis

Pulmonary Embolus - Acute - (Immediate cause of death -)

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Arteriosclerosis & Hypertension

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of Apr 18, 1929

Was there an autopsy? Yes - Johns Hopkins Hosp.

What test confirmed diagnosis? Observation at Autopsy

(Signed) C K Cunningham, M. D.

, 19 (Address) The Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Apr 24 1929

20 UNDERTAKER: Grant Crockson

ADDRESS: Baltimore

Cor.—10-10-20—A Co.—100 Bks.

E 45249

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001

E 45249
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH

City of Baltimore: (No. Johns Hopkins Hospital St., 6-10 Ward)

2-FULL NAME Chas. F. Rytina

(a) RESIDENCE NO. 400 N. Madeira St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 30/28

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	1	0	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Chas F. Rytina

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Mildred Johnson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto., Md.

14 Informant Chas F. Rytina
(Address) 400 N. Madeira St

Filed ... 19..

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 19/29

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY
(Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Hospital

(Signed) ..., M. D.

4/19/29 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL 4/22 19 29

20 UNDERTAKER Chas Goodson

ADDRESS 1706 Eutaw

APR 22 1929

Cor.—10-10-29—A Co.—100 Bks.

Deitz

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45250

CERTIFICATE OF DEATH

E 45250

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 505 Camel St. 17-24 Ward)

2-FULL NAME Ida Leetts

(a) RESIDENCE NO. 505 Camel St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Fem	Col	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robt Leetts

6 DATE OF BIRTH (month, day and year) 1876

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	53			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundress
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country) "

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Geo E. Leetts
(Address) 48 S. Stockton

C. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Oct 19th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. Leetts M. D.
(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL Oct 23 1929

20 UNDERTAKER John J. Toadvine

ADDRESS 1127 Hand Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

221929

Spec.—2-29-28—L. F. S.—500 Bks.

E 45251 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH 31 E 45253

1—PLACE OF DEATH Home

REGISTERED NO.

CITY OF BALTIMORE: (No. 113 E Hamburg St ST. 24-32 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Lillian Swift

(a) RESIDENCE NO. 113 E Hamburg St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. 6 mos. 17 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Howard F. Swift

6 DATE OF BIRTH (month, day, and year): July 7th 1906

7 AGE: Years 22 | Months 6 | Days 17 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Work

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Adam Hammel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Anna Schickner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Howard F. Swift

(Address): 113 E Hamburg St

15 [illegible] C. HANSON JONES, M. D.

Registrar

R 22 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 17th 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1928 to Apr 17, 1929, that I last saw h alive on Apr 17, 1929 and that death occurred, on the date stated above, at 9 40 AM m.

The CAUSE OF DEATH* was as follows:

Mitral stenosis & regurgitation

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Nicotinism

Apr 19 (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) W Wallace Walby, M. D.

, 19 (Address) 910 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem — DATE OF BURIAL: April 22 1929

20 UNDERTAKER: C Schlosman & Son — ADDRESS: 1034 Hanover st

Spec.—I-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45252

CERTIFICATE OF DEATH.

E 45252

REGISTERED NO. 57

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3736 Brooklyn St. (Ward) 26-25

2-FULL NAME John Ulrich

(a) RESIDENCE No. 3736 Brooklyn Ave St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. 2 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Ulrich

6 DATE OF BIRTH (month, day, and year) Feb 2 1874

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
55	2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk at Segall

(b) General nature of industry, business, or establishment in which employed (or emplo Coal Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Adam Ulrich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Annie Bauman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Emma McCarthey

(Address) Rochas Park Mt Washington

15 Filed APR 22 1929 C. HARRISON GRIES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19 1929

17 I HEREBY CERTIFY that I attended deceased from April 16 1929 to April 19 1929

that I last saw h alive on April 19 1929

and that death occurred, on the date stated above, at 4.30 P m

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John A. Schwenk, M. D.

19 (Address) 1337 E Chase St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery

DATE OF BURIAL Apr 22 1929

20 UNDERTAKER John F. Denny

ADDRESS 715 E Lexington St

TION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45253

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74 001 E 45253

1—PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST. 12-50 WARD)

2—FULL NAME Mrs Wm H. Guth

(a) RESIDENCE NO. 2229 N Charles ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred [illegible] yrs. [illegible] mos. [illegible] ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct - 15-1871

7 AGE — Years: 57 | Months: 6 | Days: 4 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Educator

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Ohio

PARENTS

10 NAME OF FATHER: George Guth

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ohio

12 MAIDEN NAME OF MOTHER: Sophie Le Grand

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Switzerland

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed APR 22 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19-29

17 I HEREBY CERTIFY, That I attended deceased from April 7, 1929, to April 19, 1929, that I last saw him alive on April 19, 1929 and that death occurred, on the date stated above, at 11 45 a. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? gennals Laboratory

(Signed) R Stroup Smith, M. D.

April 19 29 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loud Hill Cem.

DATE OF BURIAL: April 19 29

20 UNDERTAKER: John L. Mitchell & Sons

ADDRESS: 1900 Eutaw St.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45254

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 45254

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Union Memorial Hospital ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Miss Letitia Gosman

(a) RESIDENCE NO. Princeton, N. J. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug. 9, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	8	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Librarian

(b) General nature of industry, business, or establishment in which employed (or employer) Secretarial

(c) Name of employer Princeton Theol. Seminary

9 BIRTHPLACE (city or town) New York City (State or country)

PARENTS

10 NAME OF FATHER Abraham Gosman

11 BIRTHPLACE OF FATHER (city or town) N. Y. C. (State or country)

12 MAIDEN NAME OF MOTHER Letitia Howe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Missouri

14 Informant Patient's Record.

(Address)

15 Filed 2-29-1928 C. HAMPSON JONES, M. D. Registrar

221929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20, 1928

17

I HEREBY CERTIFY, That I attended deceased from October 1, 1927, to April 20, 1928, that I last saw her alive on April 20, 1928, and that death occurred, on the date stated above, at 7:05 A.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast, left, with Cerebellar metastasis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Undetermined

Did an operation precede death? Yes Date of Nov. 1, 1927

Was there an autopsy? Yes

What test confirmed diagnosis? Microscopic exam. of tissue

(Signed) Samuel McLanahan, M. D.

April 20 1928 (Address) Union Mem. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurenceville N. J. DATE OF BURIAL Apr. 24 1928

20 UNDERTAKER John O. Mitchell ADDRESS Trenton N. J.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45255

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44 E 45255

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2224 Garrison Ave. ST., 15-6L WARD)

2—FULL NAME Mary E. Meisel

(a) RESIDENCE NO. 2224 Garrison Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. 7 mos. 15 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): single

a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 5, 1851

7 AGE — Years: 77 — Months: 7 — Days: 15 — If LESS than 1 day, hrs or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Jos. H. Meisel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Mary A. McLaughlin

13 BIRTHPLACE OF MOTHER (city or (own)) (State or country): Md

14 Informant: Mr. Albert Bechler

(Address) 2503 Allendale Road

15 Filed APR 22 1929 HAMPSON JONES, M. D., Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20, 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 2, 1929, to Apr 21, 1929, that I last saw her alive on Apr 20, 1929, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach.
duration unknown
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Secondary anemia
(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Walter S. Liblett, M. D.

Apr 22, 1929 (Address) 2220 Garrison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL
Green Mount Cemy.	April 22, 1929
20 UNDERTAKER	ADDRESS
John O. Mitchell & Sons	1200 Eutaw St.

Important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45256

CERTIFICATE OF DEATH.

86-001 E 45256

1-PLACE OF DEATH Franklin Square Hospital

CITY OF BALTIMORE: (No. Calhoun & Fayette ST. 21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha M. Ferree.

(a) RESIDENCE NO. 717 Washington Blvd ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Ferree.

6 DATE OF BIRTH (month, day, and year) 1873, 1/30

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
56	1873	1	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Frederick Bunday

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Mary Mullen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Mrs. Charles Ferree

(Address) 717 Washington Blvd

15 Filed APR 22 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1929

17

I HEREBY CERTIFY, That I attended deceased from April 17, 1929, to April 21, 1929, that I last saw her alive on April 21, 1929, and that death occurred, on the date stated above, at 4:05 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral meningitis secondary to chronic pan-sinusitis and bilateral otitis media

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Spinal fluid Exam.

(Signed) Elizabeth B. Sherman, M. D.

4/24, 1929 (Address) Franklin Square Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London E. K

DATE OF BURIAL 4/23 1929

20 UNDERTAKER Clarence A. Tempel

ADDRESS 506 North St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXPLANATION of SECTION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45257

CERTIFICATE OF DEATH

94 E 45257

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS

REGISTERED NO.

CITY OF BALTIMORE: (No. [redacted] ST., 22-33 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary M. Driscoll

(a) RESIDENCE NO. 211 E. Churchill ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Driscoll

6 DATE OF BIRTH (month, day, and year) [illegible] 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
63	64	3	22.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Michael [illegible]

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Julia [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Records of

(Address)

15 Filed [illegible] 1929 C. HAMPSON JONES, M. D. Registrar

PR 22192

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1929 to April 20, 1929 that I last saw her alive on April 20, 1929 and that death occurred, on the date stated above, at 2:45 Am.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Ch Bronchitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No Physical Exam

What test confirmed diagnosis?

(Signed) Marvin M. McLean, M. D.

, 19 (Address)

*State the Disease Causing Death, or In deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross	April 23 19 29.
20 UNDERTAKER Fred A. Krause & Co	ADDRESS 7033 Harford

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45258

CERTIFICATE OF DEATH

45 E 45258

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Baltimore ST. [illegible] WARD) (If death occurred in hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Wm. Jones

(a) RESIDENCE NO. 2505 McCulloh ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Leana Jones

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Mrs Annie Harard

(Address) 1516 Jefferson St

15 Filed R 221929 C. H. HAMPSON, JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/19/25

17 I HEREBY CERTIFY, That I attended deceased from 4/14/25, to 4/19/25, that I last saw h— alive on 4/19/25, and that death occurred, on the date stated above, at 6.30 A m.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Obstruction

Obstruction of Bowels

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 4/14/25

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) W. Jefferson Jones, M. D.

, 19 (Address) Baltimore City

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cem — DATE OF BURIAL 4-21-1929

20 UNDERTAKER Byrom & Wright — ADDRESS 1218 McCulloh St

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45259 HEALTH DEPARTMENT—CITY OF BALTIMORE 74-001

CERTIFICATE OF DEATH **E 45259**

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3009 Iona Terrace ST., 22-41 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Capt. Geo. W. Shipley

(a) RESIDENCE NO. 3009 Iona Terrace ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Josephine Shipley

6 DATE OF BIRTH (month, day, and year) Jan 1 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	71	3	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Fire Dept

(b) General nature of industry, business, or establishment in which employed (or employer) Dept Capt.

(c) Name of employer Balto City

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER John Shipley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Sarah J. McGraw

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mrs. F. Seibert

(Address) 3009 Iona Terrace

15 Filed ____, 19__ SAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 18/29

17 I HEREBY CERTIFY, That I attended deceased from June ____, 19 29, to April 18, 19 29, that I last saw h__ alive on April 18 19 29 and that death occurred, on the date stated above, at 10 10 A.M. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Hypostatic Pneumonia

(duration) ____ yrs. ____ mos. 4 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) ____ yrs. ____ mos. 18 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. Duncan, M. D.

4/19, 19 29 (Address) 718 N Dallas Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL W. P. Civitan Cem.

DATE OF BURIAL Apr 21 1929

20 UNDERTAKER Philip Herwig

ADDRESS 2016 Orleans St

Important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45260 — **CERTIFICATE OF DEATH.** — 47 **E 45260**

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Church Home + Inf. St. 16-70 Ward)

2-FULL NAME Miss Bessie Thomson

(a) RESIDENCE NO. 623 Dennison St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 185

7 AGE: Years 43 Months 9 Days — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Typist

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Del

(State or country)

PARENTS

10 NAME OF FATHER: Jos. L. Thomson

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Del

12 MAIDEN NAME OF MOTHER: Annie Wiley

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Del

14 Informant: Mrs. L. D. Aspen

(Address) 3802 Parkside Drive

15 Filed ..... 19 HAMPSON JONES, M. D. Registrar

APR 22 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/21/ 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec. 22, 1928, to April 21, 1929, that I last saw her alive on April 21, 1929, and that death occurred, on the date stated above, at 9.05 A.m.

The CAUSE OF DEATH* was as follows:

General Carcinomatosis

following Carcinoma of breast.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical exam

(Signed) John Mace Jr, M. D.

, 19 (Address) Church Home + Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel Date of Burial 4/23 19 29

20 UNDERTAKER: Philip Herring ADDRESS 2016 Orleans

OF DEATH In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45261

CERTIFICATE OF DEATH

129

E 45261

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 937 S. Linwood ST., April WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Barbara Graff

(a) RESIDENCE NO. 937 S. Linwood ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced ~~HUSBAND~~ (or) WIFE of late Jacob Graff

6 DATE OF BIRTH (month, day and year) Sept 25 57

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	6	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of indostry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER John Schmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger.

12 MAIDEN NAME OF MOTHER Margaret

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger.

14 Informant Mrs Albert Sutherland

(Address) 937 S. Linwood Av

15 Filed APR 22 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14/29

17 I HEREBY CERTIFY, That I attended deceased from Feb 1 1929, to April 14, 1929, that I last saw h— alive on " " 5 P.M. and that death occurred, on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Bright's Disease

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Valvular Heart Disease (duration) 21 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) C. G. Heacock, M. D.

4/22, 1929 (Address) 940 Gorsuch Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel — DATE OF BURIAL 4/23 1929

20 UNDERTAKER Philip Herwig — ADDRESS 206 Orleans St

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

Caleb Prouty

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 45262

CERTIFICATE OF DEATH

E 45262

1—PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST. 6-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Caleb Prouty

(a) RESIDENCE NO. 1833 Fulton ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Mamie R. Prouty

6 DATE OF BIRTH (month, day, and year) Nov 7/59

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	69	5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Everett Prouty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Boston Mass

12 MAIDEN NAME OF MOTHER Mary Chisholm

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Friends

(Address) JOHNS HOPKINS HOSPITAL

15 [illegible] CHAMPION JOHNS M. D.

(Registrar)

APR 22 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20-1929

17 I HEREBY CERTIFY, That I attended deceased from April 13, 1929 to April 20, 1929 that I last saw him alive on April 20, 1929 and that death occurred, on the date stated above, at 5.10 p. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Pericarditis (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) [illegible] M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel	4/23 1929
20 UNDERTAKER Philip Kenny	ADDRESS 2016 Orleans St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45263

CERTIFICATE OF DEATH.

E 45263

1-PLACE OF DEATH Sinai Hospital

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST. 16-22 WARD)

2-FULL NAME Mrs Agnes Halick or Kiluk

(a) RESIDENCE NO. 1421 W. Lafayette Ave ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 21 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) No. 1909

7 AGE 20 Years — Months — Days | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer No.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Peter Kiluk

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russian

12 MAIDEN NAME OF MOTHER Nastazia Shiptor

13 ~~BIRTHPLACE OF~~ MOTHER (city or town) (State or country) Russian

14 Informant Peter Kiluk 1421
(Address) W Lafyette Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Sept 20 1929

17 I HEREBY CERTIFY, That I attended deceased from April 17, 1929, to April 20, 1929.

that I last saw h[illegible] alive on April 20, 1929.

and that death occurred, on the date stated above, at 10.10 A m.

The CAUSE OF DEATH* was as follows:

Biliary Peritonitis

(duration) yrs. ... mos 3 ds.

CONTRIBUTORY (Secondary) Acute Cholecystitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes 4/17/29 Date of 4/17/29

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Herman Chor M. D.

(Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Russian Independet — DATE OF BURIAL: April 23. 1929

20 UNDERTAKER: John Grebliauckas — ADDRESS: 423 S Paca St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

PR 221829

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

E 45264

CERTIFICATE OF DEATH

E 45264

1—PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1703 N. Castle St. 8-17 WARD)

2—FULL NAME Alice V. Rigney.

(a) RESIDENCE NO. 1703 N. Castle St., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Late William Rigney

6 DATE OF BIRTH (month, day, and year): Nov 25th 1870

7 AGE: Years 58 | Months 4 | Days 23 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: John Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Alice Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs L. Blomwell

(Address) 1904 N. Leadenhall ave

15 Filed Apr 22 1929, by HAMPTON JONES M.D. Registrar

APR 22 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 18, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1929, to April 15, 1929, that I last saw h.. alive on April 15, 1929 and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

..... (duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) J. S. Hamm, M. D.

(Address) 1301 N. Patterson Pk

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery

DATE OF BURIAL: April 22 1929

20 UNDERTAKER: Geo. A. Roth

ADDRESS: 1735 Harford ave

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45265 — CERTIFICATE OF DEATH — E 45265

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS — REGISTERED NO.

CITY OF BALTIMORE: (No. ... ST. 2-4 ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Bosse

(a) RESIDENCE NO. 241 S. Wolfe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. life — How long in U. S., if foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Records of

(Address) BALTIMORE CITY HOSPITALS

15 Filed APR 22 1929 HAMPSON GUNDRY, Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 20, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 11, 19 29, to April 20, 19 29, that I last saw her alive on April 20, 19 29, and that death occurred, on the date stated above, at 5:30 A m.

The CAUSE OF DEATH* was as follows:

Thrombosis of Cerebral artery with right Hemiplegia

(duration) ... yrs. ... mos. 14 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) Marvin H. M. Lam M. D.

BALTIMORE CITY HOSPITALS

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
OAK LAWN CEMETERY	APR. 22 19 29
20 UNDERTAKER: Henry Sander & Sons, Inc.	ADDRESS: BALTIMORE ST. & BROADWAY.

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45266

CERTIFICATE OF DEATH

124

E 45266

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST., 7-1-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Shooks

(a) RESIDENCE NO. 371 Scott ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Don't Know

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
75				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Henry Shooks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Wisley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Records (Address)

15 Filed ..., 19... HAMPSON JONES, M. D. Registrar

R 22 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-20-29

17 I HEREBY CERTIFY, That I attended deceased from 4-17, 1929, to 4-20, 1929

that I last saw h[illegible] alive on 4-20, 1929

and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Emphysema of Gall Bladder

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John E. Moran, M. D.

, 19 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Matthews Cem

DATE OF BURIAL April 20, 1929

20 UNDERTAKER John Ellerick

ADDRESS 2008 Orleans

Spec.—2-29-28—L. F. S.—500 Blks.

E 45267 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 ✓ **E 45267**

CERTIFICATE OF DEATH

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

CITY OF BALTIMORE: (No. 10-14 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Nathon Coffer

(a) RESIDENCE NO. 743 Ajax Alley ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or partirular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Wm. Coffer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: ? Pritter

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Records of
(Address)

Filed APR 22 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 18, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1928, to April 18, 1929, that I last saw him alive on April 18, 1929 and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

Chr. myocarditis (duration) 9 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? X-Ray - Physical.

(Signed) [illegible], M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Calvary	Apr. 23 1929

20 UNDERTAKER: Reynolds Brothers

ADDRESS: 1718 Madison Ave

Important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

45268

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45268

CERTIFICATE OF DEATH.

161-002

1-PLACE OF DEATH Franklin Square Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 27-43 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Deegan

(a) RESIDENCE NO. 3812 Bayonne Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: Colrite

5 Single, Married, Widowed, or Divorced, (write the word): Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: new born

6 DATE OF BIRTH (month, day, and year): April 21, 1929

7 AGE — Years — Months — Days — If LESS than 1 day 16 hrs or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md

PARENTS

10 NAME OF FATHER: Louis James Deegan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Canton, Balto. Co., Md

12 MAIDEN NAME OF MOTHER: Lynch

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore, Md

14 Informant: Father

(Address): —

15 Filed: 1929 Registrar: C. H. Young Jones, M. D.

R 21929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 21. 1929

17 I HEREBY CERTIFY, That I attended deceased from 4-20 .1929. to 4-21 .1929.

that I last saw h/m alive on 4-21 .1929.

and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Accident of Labor
Forceps delivery
Asphyxia posterior
Contracted Pelvis (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) Arthur Rattenni, M. D.

4/21. 1929 (Address) Franklin Sq. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Most Holy Redeemer Cemetery | DATE OF BURIAL: April 22 29

20 UNDERTAKER: Elmer W. Conklin | ADDRESS: 924 E Eager St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45209

CERTIFICATE OF DEATH

118-002

E 45269

1-PLACE OF DEATH Communicable Ward

City of Baltimore: (No. St Joseph Hospital St., 8-17 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Ramolo Gabrielli

(a) RESIDENCE NO. 1917 E. Federal St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed or Divorced, (write the word): Widiwer

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb 9/1876

7 AGE: Years 53 | Months 2 | Days 11 | IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Plasterer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country): Italy

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Italy

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Italy

14 Informant: Florence Gabrielli
(Address): 1917 E. Federal St

15 Filed ..., 19... HARRY JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 19/29

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry). find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

(Intestinal Obstruction-cause undetermined) (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature], M. D.

4/22/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: May 23 19 29

20 UNDERTAKER: Ephit Peruzzi Sons — ADDRESS: 1742 N. Avon

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45270

CERTIFICATE OF DEATH

5 E 45270

REGISTERED NO.

1—PLACE OF DEATH St Joseph Hospital

CITY OF BALTIMORE: (No. Caroline & Eden WARD) 11

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Ellen McDonald

(a) RESIDENCE NO. 2807 E Preston St. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 ~~Single~~, Married, ~~Widowed, or Divorced~~, (write the word): married

5a If ~~married, widowed, or divorced~~ HUSBAND of (or) WIFE of: Edward J McDonald

6 DATE OF BIRTH (month, day, and year): April 9-1866

7 AGE: Years 63 | Months | Days 13 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Patrick McDonald

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Bridget McIntyre

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Edward J McDonald

(Address) 2807 E Preston St

APR 22 1929

Filed ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-21-29.

17 I HEREBY CERTIFY, That I attended deceased from 3-26-29, 19..., to 4-21-29, 19..., that I last saw h[er] alive on 4-21-29, 19..., and that death occurred, on the date stated above, at 7 9 m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

..... (duration) 10 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Chronic Nephritis X

Carcinoma (duration) ..... yrs. ..... mos. 14 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 4/11/29 Right Amputation

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) J B Hendrix, M. D.

19 (Address) Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral

DATE OF BURIAL: Apr 24 19 29

20 UNDERTAKER: Robt J Turner

ADDRESS: 1742 W Fayette

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 45271

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 45271

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. South Baltimore General Hospital St., 8-13 Ward) 185

2-FULL NAME Clarence S. Dickerson

(a) RESIDENCE NO. 1517 E. Biddle St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White.	Married

5a If married, HUSBAND of Emma F. Dickerson.

6 DATE OF BIRTH (month, day, and year) August 8, 1894

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	34	8	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Crane foreman,
(b) General nature of industry, business, or establishment in which employed (or employer) Union Shipbuilding Co.
(c) Name of employer

9 BIRTHPLACE (city or town) Oklahoma.
(State or country)

PARENTS

10 NAME OF FATHER Frank Dickerson.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Emma Dickerson. (wife)
(Address) 1517 E. Biddle St.

15 Filed 10 C. HAMPSON JONES, M. D. Registrar

R 22 1929

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19, 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull
Accidental fall into hold of
steamship Natural Bridge
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Union Shipbuilding Co Fairfield.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Investigation.

(Signed) [illegible], M. D.

4/22. 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Int Ohnt — DATE OF BURIAL 4/22 1929

20 UNDERTAKER William Coole — ADDRESS 1275 Law

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45272

CERTIFICATE OF DEATH

185 E 45272

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hosp ST. 16-23 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emily Stockdale

(a) RESIDENCE NO. 922 Harlem Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 7, 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80		13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Benjamin C Stockdale

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Hannah C Lukens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant G. E. Stockdale

(Address) 922 Harlem Ave

15 Filed APR 22 1929 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20, 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb. 23, 1929, to March 20, 1929, that I last saw h[illegible] alive on March 20, 1929, and that death occurred, on the date stated above, at 4:00 P. m.

The CAUSE OF DEATH* was as follows:

Fracture of neck of right femur

(duration) — yrs. 1 mos. 26 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. — mos. 8 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) F. H. Simpson, M. D.

4/20, 1929 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Forrane Cemetery

DATE OF BURIAL 4/22 1929

UNDERTAKER William Cook

ADDRESS 1217 St Paul

IMPORTANT: See instructions on back of certificate

Cor.—10-10-29—A Co.—100 Bks.

E 45273 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001

E 45273
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hosp. St. 14-20 Ward)

2-FULL NAME Geo. Burs.

(a) RESIDENCE NO. 1639 Division St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 Color or Race: Col. | 5 Single, Married, Widowed or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: None.

6 DATE OF BIRTH (month, day and year): 1900

7 AGE: Years 29 | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): O'D
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant (Address) Provident Hosp. Records Druid St.

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

3506 Per .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 14 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Fleischner M. D.

April 15 1929 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND — DATE OF BURIAL: 19

20 UNDERTAKER — ADDRESS

APR 22 1929

APR 22 1929

Per Wm. E. WOODALL

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45274 CERTIFICATE OF DEATH. E 45274

1-PLACE OF DEATH

City of BALTIMORE: (No. [illegible] Fallsway & Lombard St. Gonaku's Lab. 66 St., [illegible] Ward)

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME [illegible]

(a) RESIDENCE NO. [illegible] St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): [illegible]

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years: about 3-0 — Months — Days — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant
(Address)

Filed APR 22 1929 HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 4 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Alcoholism

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary)

(duration) ____ yrs. ____ mos. ____ ds.

Apr. 19 (Signed) [illegible] M. D.
(Coroner)
, 1929 (Address) 1659 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial 19

20 UNDERTAKER — ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

UNIVERSITY OF MARYLAND

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45275

CERTIFICATE OF DEATH

151 ✓

E 45275

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1 Altamont Ave ST., 26 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Taylor

(a) RESIDENCE NO. ..... ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years: 45 — Months — Days — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: ✓

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant

(Address)

15 Filed ..... C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/16/25

17

I HEREBY CERTIFY, That I attended deceased from 4/14, 19 25, to 4/16, 19 25,

that I last saw h... alive on 4/16, 19 25

and that death occurred, on the date stated above, at 11.30 A m.

The CAUSE OF DEATH* was as follows:

Acute Glanders

(Bronchopneumonia)

2 hrs (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Microscopical Exam

(Signed) R. M. Slack, M. D.

, 19 (Address) Balto City Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

UNIVERSITY OF MARYLAND

Commissioner of Health

APR 29 1929

PR 22 Feb

Important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

45276

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+ 38 E 45276

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No. 1111 Monument ST. 1-72 WARD)

2-FULL NAME Isadore Herford

(a) RESIDENCE NO. Essex 1111 ST., WARD Essex, 11th

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Etta Herford

6 DATE OF BIRTH (month, day, and year): June 9, 1878

7 AGE: Years 50 Months 10 Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Samuel S. Herford

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Carrie Moly

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N.Y.

14 Informant: Nathan Lazarus

(Address) Temple Oheb Shalom

15 Filed APR 22 1929 RAYMOND JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-20-1929

17 I HEREBY CERTIFY, That I attended deceased from March 2, 1929, to April 19 1929.

that I last saw him alive on April 19, 1929.

and that death occurred, on the date stated above, at 11:30 p.m.

The CAUSE OF DEATH* was as follows:

Syphilis

(Central Nervous System)

(Paresis)

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) A. A. Epstein M. D.

, 19 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oheb Shalom — DATE OF BURIAL: 4-23 1929

20 UNDERTAKER: David Sandheim — ADDRESS: 1111 W. Lanvale

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause of death TION is very important. See instructions on back of certificates.

Spec. E 45277 —200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45277

CERTIFICATE OF DEATH

REGISTERED NO. 161-00

1-PLACE OF DEATH

City of BALTIMORE: (No. 1603 Hasselby Place St., 8 Ward 13)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Marie Lewis

(a) RESIDENCE NO. 1603 Hasselby Pl St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 2½ ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Apr. 19, 1927

7 AGE: Years — Months — Days 2½ — IF LESS than 1 day ..hrs. or ..min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country): Md

PARENTS

10 NAME OF FATHER: Harry Lewis

11 BIRTHPLACE OF FATHER (City or town): Balto

(State or country): Md.

12 MAIDEN NAME OF MOTHER: Anna M Emmert

13 BIRTHPLACE OF MOTHER (city or town): Balto

(State or country): Md

14 Informant: Mr. Harry Lewis

(Address): 1603 Hasselby Place

15 Filed APR 22 1929 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr. 21st, 1929

17 I HEREBY CERTIFY, That I attended deceased from 4-19-29, 19.., to 4-21-29, 19.., that I last saw h[illegible] alive on 4-21-29, 19.., and that death occurred, on the data stated above, at 1:30 (a.m.)

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) .. yrs. .. mos. .. da.

CONTRIBUTORY (Secondary)

(duration) .. yrs. .. mos. .. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] Attending, M. D.

4-21-1929 (Address) 2214 E Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery

Date of Burial: April 22 1929

20 UNDERTAKER: Henry Hauck & Sons

ADDRESS: 1301 E Eager St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 45278

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 45278

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Balto. (St.) (Ward) 65

REGISTERED NO. 2455

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Eulalia Blumenauer

(a) RESIDENCE No. 3516 Menlo Drive ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. 3 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: fem

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Louis Airey Blumenauer

6 DATE OF BIRTH (month, day, and year): Jan 2 1899

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
30	3	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Fred H. Einwaechter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Cora A. Ruhl

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md

14 Informant: Mr. Louis A. Blumenauer

(Address) 3516 Menlo Drive.

Filed APR 22 1929 WILSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 22nd 29

17 I HEREBY CERTIFY, That I attended deceased from March 23, 1929, to April 22, 1929, that I last saw h[illegible] alive on April 22, 1929, and that death occurred, on the date stated above, at 3:10 a.m.

The CAUSE OF DEATH* was as follows:

Splenomyelogenous Leukemia

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Laboratory

(Signed) Benj. Sarubin, M. D.

, 19 (Address) West Balto. Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem — DATE OF BURIAL: Apl 24 1929

20 UNDERTAKER: Wm Pickner Sons — ADDRESS: North & Pa

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45279

CERTIFICATE OF DEATH

5 7

E 45279

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 750 Poplar Grove St. 16-67 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John W. B. Holmes

(a) RESIDENCE NO. 750 Poplar Grove ST.

(Usual place of abode) WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 6 mos. 19 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary E Holmes

6 DATE OF BIRTH (month, day, and year): Oct 1-1869 C.

7 AGE — Years: 59 | Months: 6 | Days: 19 | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Bricklayer

(b) General nature of industry, business, or establishment in which employed (or employer): 011

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: John T. Holmes

11 BIRTHPLACE OF FATHER (city or town) (State or country): City

12 MAIDEN NAME OF MOTHER: Elizabeth J. Grisco

13 BIRTHPLACE OF MOTHER (city or town) (State or country): City

14 Informant: John T. Holmes

(Address) 750 Poplar Grove

15 Filed APR 22 1929 C. E. JEFFERSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 20, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1928, to April 20, 1929

that I last saw h alive on April 20, 1929

and that death occurred on the date stated above, at 10 30 m.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? He not know

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urine Analysis

(Signed) L. C. Lall, M. D.

19 (Address) 3517 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: Apr 22 1929

20 UNDERTAKER: H. G. Tuckner & Son — ADDRESS: North Ave

Spec.—2-29-28—L. F. S.—500 Bks.

E 45280

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

46

E 45280

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3023 E. Baltimore ST. 1-2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME JENNIE E. WILEY

(a) RESIDENCE NO. 3023 E. Baltimore ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of James A. Wiley

6 DATE OF BIRTH (month, day, and year) January 1,1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	3	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John Cooksey

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Sophia Shaw

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mrs. May Jones (Daughter)

(Address) 3023 E. Baltimore St.

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20, 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 7, 19 29 to April 20, 19 29

that I last saw h[illegible] alive on April 20, 19 29

and that death occurred, on the date stated above, at 11.00 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma cervix uteri

Chr myocarditis

Mitral insufficiency (duration) yrs. 18 mos. ds.

CONTRIBUTORY (Secondary) Hypostatic pneumonia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin data

(Signed) Leo Schlesinger, M. D.

19 (Address) 3034 E Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery

DATE OF BURIAL Apr. 23, 19 29

20 UNDERTAKER Henry Sander & Sons, Inc.

ADDRESS BALTIMORE ST. & BROADWAY.

Spec.—1-12-23—M&T—500 Bks.

E 45281 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45281

CERTIFICATE OF DEATH

1-PLACE OF DEATH Provident Hospital 31

CITY OF BALTIMORE: (No. 1514 Division St. 11-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Thomas

(a) RESIDENCE NO. 241 W Preston ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Child

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years: 5 — Months: — — Days: — — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balt. Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant

(Address)

15 4 21 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 17 1929

17 I HEREBY CERTIFY, That I attended deceased from March 23 1929 to April 17, 1929, that I last saw h[illegible] alive on April 17, 1929, and that death occurred, on the date stated above, at 6 10 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Undetermined

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? X-Ray Autopsy

(Signed) C. L. Talkin M. D.

4/17 1929 (Address) Provident Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL D. 19

20 UNDERTAKER

ADDRESS

Commissioner Health.

APR 22 1929

TION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 45282

HEALTH DEPARTMENT—CITY OF BALTIMORE

V
X 74-082

E 45282

CERTIFICATE OF DEATH

1-PLACE OF DEATH Md General Hosp. REGISTERED NO.

City of BALTIMORE: (No. Howard & Madison St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert H Barnes.

(a) RESIDENCE NO. Westminster, Md. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 12 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Married

6 DATE OF BIRTH (month, day, and year): 1871

7 AGE: 58 Years Months Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: John W Barnes

11 BIRTHPLACE OF FATHER (City or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Martha Hook

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Hospital Records

(Address)

Filed APR 22 1929 C. HAMPSON JONES, M. D. Registrar

PR 22 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 22 1929

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1929, to April 22, 1929

that I last saw h. in alive on April 22, 1929

and that death occurred, on the date stated above, at 2-15 P. m.

The CAUSE OF DEATH* was as follows:

Gastric Ulcer

(duration) 10 yrs. ? mos. ds.

CONTRIBUTORY (Secondary) Cerebral Embolism

(duration) yrs. mos. ½ ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of April 12

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinical

(Signed) H. H. Karpschmidt M. D.

4/22, 1929 (Address) Md General Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Westminster Md — Date of Burial: 4-25 1929

20 UNDERTAKER: H Bankard & Son — ADDRESS: Westminster Md

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45283

HEALTH DEPARTMENT—CITY OF BALTIMORE

V 24-001

CERTIFICATE OF DEATH

E 45283

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 822 N. Central Ave ST. 10-14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Eliza. R. Mc Farland

(a) RESIDENCE NO. 822 N. Central Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 78 yrs. — mos. — ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow.

6 If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER M. Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs. Annie E. Foster

(Address) 214 Somerset Terrace

15 C. HAMPSON JONES, M.D.

Registrar

R 21929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 21 1929

17 I HEREBY CERTIFY, That I attended deceased from April 16 1929 to April 21 1929 that I last saw h alive on April 20th 1929 and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. Tolmer, M. D.

April 22, 1929 (Address) 1501 E. Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery DATE OF BURIAL Apr. 23 1929

20 UNDERTAKER Henry Strech Sons Inc. ADDRESS 1301 E Eager St

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45284

CERTIFICATE OF DEATH.

52

E 45284

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3311 Barclay St. 17-4-4 Ward)

2-FULL NAME James Childs

(a) RESIDENCE NO. 3311 Barclay ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 23 24

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	4	9	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Jrgnl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) City
(State or country)

PARENTS

10 NAME OF FATHER Thomas Childs

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Lucy Neal

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) St Marys Co

14 Informant Bessie Childs
(Address) 3311 Barclay

15 Filed APR 21 1929 C. HAMPSON JONES, M. D., Registrar
By ACH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month) April 20 yr 1929

17 I HEREBY CERTIFY, That I attended deceased from April 11 yr, 1929, to April 20 yr 1929.

that I last saw him alive on April 19 yr, 1929

and that death occurred, on the date stated above, at P M.

The CAUSE OF DEATH* was as follows:

Acute Rheumatic Endocarditis

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Rheumatic Carditis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam

(Signed) C. Hampson Jones M.D.

11/27/29 (Address) 401 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL April 23 1929

20 UNDERTAKER James L. Wilson & Son

ADDRESS

IMPORTANT is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 45285

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 45285

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 424 S. Highland Ave ST. 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jacob Hoehn

(a) RESIDENCE NO. 424 S. Highland Ave ST. 26 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs. Rosa Kunigunda Hoehn

6 DATE OF BIRTH (month, day, and year): Feb 17 1847

7 AGE — Years: 82 — Months: 2 — Days: 1 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Andrew Hoehn

(Address) 424 S. Highland Ave

15 C. HAMPSON JONES, M. D.

Registrar

R 221929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 20th 1929

17 I HEREBY CERTIFY, That I attended deceased from April 10 1929 to April 20 1929.

that I last saw him alive on April 18 1929

and that death occurred, on the date stated above, at 4 p.m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary): senile

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) P. O'Donovan M. D.

April 21st 1929 (Address) 1710 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cemetery — DATE OF BURIAL: April 24 1929

20 UNDERTAKER: Lahey & Sons — ADDRESS: 40 E. Lexington

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45286

CERTIFICATE OF DEATH

90

E 45286

1—PLACE OF DEATH

REGISTERED NO. 26-2

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3231 Fleet ST. 26 WARD)

2—FULL NAME Jacob Kirchner

(a) RESIDENCE NO. 3231 Fleet ST. 26 WARD
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., If foreign birth? 57 yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Veronica Kirchner

6 DATE OF BIRTH (month, day, and year) July 29th 1835

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
93	8	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary M. Buettner

(Address) 1703 Lanvale ave.

15 Filed APR 22 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20th 29

17 I HEREBY CERTIFY, That I attended deceased from April 18, 1929, to April 20, 1929, that I last saw him alive on April 19, 1929 and that death occurred, on the date stated above, at 10.20 a. m.

The CAUSE OF DEATH* was as follows:

Mitral & Aortic Insufficiency

(duration) 1 yrs. or mos. ds.

CONTRIBUTORY (Secondary) Break in Compensation

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Caleb N Bitter, M. D.

April 22, 1929 (Address) 105 S Fillmore Ave Canton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	April 23rd 1929
20 UNDERTAKER Lilly & Zeiler Inc	ADDRESS 4032 Wyaco

Spec.—1-10-21—M&T—1500 Bks.

E 45287 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 45287

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2206 Fleet ST. 1 (WARD) 13

2-FULL NAME Daniel Griebel

(a) RESIDENCE No. 2206 Fleet ST., 1 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 20th 1914

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	14	7 10	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: attendant at school

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER George Griebel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Mary Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant (Address) Mary Griebel (Mother) 2206 Fleet St.

15 Filed 19 Registrar C. HAMPSON JONES, M. D.

R 22 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21st 1929

17 I HEREBY CERTIFY, That I attended deceased from March 30 , 1929 , to April 21 , 1929 , that I last saw h alive on April 21 , 1929 , and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) yrs. unknown

CONTRIBUTORY (Secondary) arthritis chronic

(duration) yrs. unknown mos.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank Hampson Jones M. D.

19 29 (Address) 243 East Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: April 24 1929

20 UNDERTAKER: Kelly & Sullivan Inc — ADDRESS: 405 S. Mich Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF ... TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 45288

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 45288

REGISTERED NO. 35

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 438 E 23d St. ST. 17-50 WARD)

2-FULL NAME Clifton B. Westcott

(a) RESIDENCE NO. 438 E 23d St. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Betty

6 DATE OF BIRTH (month, day, and year): Feb. 20-1893

7 AGE: Years 36 | Months 1 | Days 24 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Letter Carrier

(b) General nature of industry, business, or establishment in which employed (or employer): U.S.P.O.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): N. J.

PARENTS

10 NAME OF FATHER: Johnson B. Westcott

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Vandelia Hampton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Mrs. Vandelia Hampton

(Address): 438 E. 23d St.

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.

2 21 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 20 1929

17

I HEREBY CERTIFY, That I attended deceased from Jan. 28, 1929, to April 20, 1929.

that I last saw h[illegible] alive on April 20, 1929

and that death occurred, on the date stated above, at 3:30 A. m.

The CAUSE OF DEATH* was as follows:

Acute Tubercular Arthritis and peritonitis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Acute Arthritis

Exposure (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of no

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) I. D. Hall M. D.

. 19 (Address) 426 E 23d St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Sulcidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn

DATE OF BURIAL: 7/23/1929

UNDERTAKER: Wm. Geo. H. Keller

ADDRESS: 1631 Druid Hill Ave

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

Dr Condon 3707 Calloway Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45289

CERTIFICATE OF DEATH

4/4

E 45289

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 8 N. Calhoun ST. 19-76 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Julia Loyttelon Dallam

(a) RESIDENCE NO. 8 N. Calhoun ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
50	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Police Chief

(b) General nature of industry, business, or establishment in which employed (or employer) 061

(c) Name of employer Montgomery Ward

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER John T. Dallam

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Mary E. Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Alfred T. Dallam

(Address) Baltimore Md.

15 Filed 2 27 1929 19 HAMPSON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22nd 1929

17

I HEREBY CERTIFY, That I attended deceased from Aug 1st, 1928, to Apr 22nd, 1929, that I last saw him alive on Apr 22, 1929 and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Throat

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Vernon N Condon, M. D.

19 (Address) 3707 Calloway Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL 4 23 1929

20 UNDERTAKER John Cook

ADDRESS 217 S Eutaw St

Spec.—1-10-21—M&T—1500 Bks.

E 45290

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45290

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Franklin Square Hospital

CITY OF BALTIMORE: (No. Calhoun & Fayette ST.) 13-59 (WARD)

REGISTERED NO. 57

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Wilke

(a) RESIDENCE NO. 2802 Woodbrook Ave ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frederick Wilke

6 DATE OF BIRTH (month, day, and year): Oct 22, 1852

7 AGE: Years 76 Months 3 Days 29 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: At home

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: George Schmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Barbary Kramer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Betty Haus

(Address) 2802 Woodbrook Ave

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 21 1929

17

I HEREBY CERTIFY, That I attended deceased from April 5, 1924, to April 21, 1929, that I last saw her alive on April 21, 1929, and that death occurred, on the date stated above, at 11:40 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

Generalized arteri sclerosis

(duration) yrs. ? mos ds.

CONTRIBUTORY (Secondary) Infection of left knee & Cellulitis of thigh (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? Yes Date of 4/8/29

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Elizabeth B Sherman M. D.

4/21, 1929 (Address) Franklin Square Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount

DATE OF BURIAL: 4/24 1929

20 UNDERTAKER: W M Cook

ADDRESS: 1214 E Fayette

221929 C. HAMPSON JONES, M. D. Registrar

Per MKH

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF DISEASE OR CONDITION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 4529T

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 45291

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2803 Brooklyn ST., WARD) 16-68

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna Mary Louise Schild

(a) RESIDENCE NO. 2803 Brooklyn ST., WARD Red Lion Pa

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jacob A. Schild

6 DATE OF BIRTH (month, day, and year): Aug 20-1849

7 AGE — Years: 79 — Months: 8 — Days: 2 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: John Gemmill

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa

12 MAIDEN NAME OF MOTHER: Susan Lantz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant: Mrs. Hall

(Address): Stewartstown Pa

15 Filed: 4 2 1929 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 22-1929.

17 I HEREBY CERTIFY, That I attended deceased from Apr 19, 1929, to Apr 22, 1929

that I last saw her alive on Apr 22, 1929

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

CONTRIBUTORY (Secondary) Pulmonic Tuberculosis (duration) yrs. 1 mos. 2 ds.

Acute Dilatation of Heart (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Place of Death

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys Exam

(Signed) John A. Heaton M. D.

Apr, 1929 (Address) 1219 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Evergreen York County Pa — DATE OF BURIAL: April 2 1929

20 UNDERTAKER: J. H. Hall — ADDRESS: Stewartstown Pa

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45292

CERTIFICATE OF DEATH.

118-001

E 45292

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2020 Portugal St. 2-4 Ward)

2-FULL NAME John Kuchcinski (John. Kuchcinski)

(a) RESIDENCE NO. 2020 Portugal St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? 46 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) Dec 18 1881

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	47	4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Common

(c) Name of employer Southern Can Co.

9 BIRTHPLACE (city or town) _____

(State or country) Poland

PARENTS

10 NAME OF FATHER William Kuchcinski

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Poland

12 MAIDEN NAME OF MOTHER Mary Chmielewska

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Poland

14 Informant Mary Kuchcinski

(Address) 2020 Portugal St

Filed _____ 19__ C. HAMPSON JONES, M. D.

Per _____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Encarcerated Hernia

(duration) ____ yrs. 6 mos. ____ ds.

CONTRIBUTORY (Secondary) Acute Rupture / Hernia

with Coma (duration) ____ yrs. ____ mos. 3 ds.

(Signed) H. Benton M. D.

(Coroner)

4 20 1929 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Stanislaus Date of Burial: April 23 1929

20 UNDERTAKER: John M Weber ADDRESS: 701 E Chester St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

R 221929

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45293

CERTIFICATE OF DEATH.

E 45293

REGISTERED NO. 89

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 640 S. Lemmon ST.) 17 WARD)

2-FULL NAME Joseph Biancanella

(a) RESIDENCE NO. 640 S. Lemmon ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carolina Biancanella

6 DATE OF BIRTH (month, day, and year) June 11 1844

7 AGE 83 Years 2 Months 9 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) O'Neill

(c) Name of employer City Sewerage

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Antonio Biancanella

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Carmelia Antonucci

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Louis Biancanella

(Address) 640 S. Calhoun ave

15 221929 G. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20, 1929

17 I HEREBY CERTIFY, That I attended deceased from April, 1929, to April 20, 1929, that I last saw him alive on April 14, 1929, and that death occurred, on the date stated above, at 2.20 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Eugene L Peters M. D.

April 22, 1929 (Address) 519 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL April 23 1929

20 UNDERTAKER Kendall & Leppert

ADDRESS 2008 Eden

CAUSE OF DEATH MUST BE FILLED IN. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45294

CERTIFICATE OF DEATH.

179 E 45294

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. City Hospital St. 6-11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Angeline Szymanski

(a) RESIDENCE NO. 136 N. Streeper St. St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 3 1926

7 AGE Years	Months	Days 18	IF LESS than 1 day.....hrs. or.....min.
3	2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore

PARENTS

10 NAME OF FATHER Edward Szymanski

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore

12 MAIDEN NAME OF MOTHER A. Gostumski

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant Edward Szymanski

(Address) 136 N. Streeper St.

Filed ... 19... C. HAMILTON LEWIS, M. D.

APR 23 1929 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Burns from Gas stove

Clothes caught fire 2

(duration) yrs. mos. ds.

(Signed) James M. Hanlon M. D.

(Coroner)

4 22 1929 (Address) 700 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death 3 yrs. 8 mos. 7 wks. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

136 N Streeper

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Date of Burial Apr. 24 1929

20 UNDERTAKER F.H. Ozazewski ADDRESS 1930 Eastern Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

Schaub

E 45295 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 ✓

E 45295

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 442 Fulton Ave ST.) 12-50 (WARD)

2—FULL NAME Margaret Schaub.

(a) RESIDENCE NO. 442 Fulton Ave ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob A Schaub.

6 DATE OF BIRTH (month, day, and year) May 2nd 1876

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
52.	11	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife 07

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER Samuel Talbert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary McGraw

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mr Jacob A Schaub.

(Address) 442 Fulton Ave

15 [illegible] C. HAMPSON JONES, M. D.
Registrar

R 23 1929

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21st 1929.

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1927, to April 21, 1929, that I last saw him alive on April 20, 1929 and that death occurred, on the date stated above, at 9 A. m.

The CAUSE OF DEATH* was as follows:

Chr Myocarditis
Chr Int Nephritis
Hypothyroidism

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) E. L. Bishop, M. D.

1929 (Address) 501 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	April 24 1929
20 UNDERTAKER John J Cowan & Son	ADDRESS 900 Hollins

Important: See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 45296

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

E 45296
REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3317 Shelburne Road ST., 27-65 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME J.Frank Wilhelm,

(a) RESIDENCE NO. 3317 Shelburne Road ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of Kate W.Wilhelm,

6 DATE OF BIRTH (month, day, and year) July 27.1848

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
80	8	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Heating & Stove

(b) General nature of industry, business, or establishment in which employed (or employer) Business

(c) Name of employer Himself

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Jacob H.Wilhelm

11 BIRTHPLACE OF FATHER (city or town) (State or country) Philadelphia Penna.

12 MAIDEN NAME OF MOTHER Mary Louise Webb

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Mrs A Wilhelm
(Address) 3317 Shelburne Rd

15 Filed 4-23-1928 H. LLEWELLYN JONES, M. D. Registrar

R 23928

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY, That I attended deceased from April 19, 1928, to April 22, 1928, that I last saw him alive on April 19, 1928, and that death occurred, on the date stated above, at 5 [illegible] m.

The CAUSE OF DEATH* was as follows:

Myocarditis

CONTRIBUTORY (Secondary) Acute dilatation of Heart (duration) yrs. 3 mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H W Hemminter, M. D.

4-23, 1928 (Address) 3002 Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL 19

20 UNDERTAKER Geo W Little — ADDRESS

Spec.—2-29-28—L. F. S.—500 Blks.

E 45297 HEALTH DEPARTMENT—CITY OF BALTIMORE 129 E 45297

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1102 N. Strieker ST. 16-22 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alverta Traverse

(a) RESIDENCE NO. 1102 N. Strieker ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 1 mos. 3 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Married

5a If married, widowed, or divorced (or) WIFE of Edward Traverse

6 DATE OF BIRTH (month, day, and year) Feb 6 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	1	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Richard Garrett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Edward Traverse
(Address) 1102 N. Strieker

15 [illegible] Registrar

R 23 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 22-29

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1929, to April 22, 1929, that I last saw h[illegible] alive on April 21, 1929 and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Chr Parenchymatous Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urinalysis

(Signed) J. W. Beard M. D.

4/22, 1929 (Address) 2005 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Apr 27 1929

20 UNDERTAKER	ADDRESS
Jno. M. Chase & Son	1400 Mosher

Spec.—2-29-28—L. F. S.—500 Hks.

E 45298 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 45298

I—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1927 Gough st. ST. 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Eva. a Mach.

(a) RESIDENCE NO. 1927 Gough st. ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White	Single

6 DATE OF BIRTH (month, day, and year) Dec-22-1902.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
26	4	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home. Work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore md.

PARENTS

10 NAME OF FATHER Joseph. mach.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Josephine. Zahanowa.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Joseph. mach.
(Address) 1927. Gough st.

15 Filed 23 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 21 '29

17 I HEREBY CERTIFY, That I attended deceased from April 13 . 1929 . to Apr. 21 . 1929. that I last saw her alive on Apr. 21 . 1929 and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Geo. D. Libby, M. D.

, 19 (Address) 432 S. Patterson Pk. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cemetery	April 25 1929.

20 UNDERTAKER George A. Weber ADDRESS 706 Lanvale st.

Spec.—1-10-21—M&T—1500 Bks.

E 45299

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 45299

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 519 S. Regester st. ST. 7-4 WARD)

2-FULL NAME Mary Jacka

(a) RESIDENCE NO. 519 So Regester St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE Years 75 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland.

PARENTS

10 NAME OF FATHER Wozniak

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant Vincent Jacka Son.

(Address) 228 S Ann street

15 Filed [illegible] 1929 C. HAMPSON, JR., M. D. Registrar

PR 23 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 1929

17 I HEREBY CERTIFY, That I attended deceased from April 18, 1929, to April 19, 1929.

that I last saw h[illegible] alive on April 19, 1929,

and that death occurred, on the date stated above, at 8.20 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Senile Myocarditis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Joseph L. Valentine, M. D.

April 20, 1929 (Address) 14 So Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

St. Stanislaus Cemetery April 24 1929.

20 UNDERTAKER — ADDRESS

George A. Weber 705 S Ann st.

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45300
1-PLACE OF DEATH

CERTIFICATE OF DEATH

185

E 45300
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of Baltimore: (No. 20 E. Churchill St. St. 27-33 Ward)

2-FULL NAME William Brown.(C)

(a) RESIDENCE NO. 20 E. Churchill St. St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Married.

5a If married, widowed or divorced, HUSBAND of ~~XXXXXXXXXX~~ ~~XXXXXX~~ Sadie Brown.(C)

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	45	----------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Virginia.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Hester Emerson.(C)
(Address) 700 S. Charles St.

15 Filed ..... 19 .....
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 15, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute dilatation of the Heart.
Probable fracture of the skull
Occicental fall down stairway.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? History.

(Signed) [illegible], M. D.

4/20. 1929 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL Apr 24 19

20 UNDERTAKER John W. Goadby

ADDRESS 1027 Hanover

APR 23 1929 U.S. SANITARY DISTRICT

Spec.—2-29-28—L. F. S.—500 Bks.

Joshua Fisher

E 45301

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45301

CERTIFICATE OF DEATH

BALTIMORE CITY HOSPITALS

1—PLACE OF DEATH

REGISTERED NO. 90

CITY OF BALTIMORE: (No. 14-20 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Johsna Fisher

(a) RESIDENCE NO. 1419 Myrtle Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Separated

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Waiter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Records of

(Address)

BALTIMORE CITY HOSPITALS

15 APR 23 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 21, 1929

17

I HEREBY CERTIFY, That I attended deceased from April 17, 1929 to April 21, 1929

that I last saw him alive on April 21, 1929

and that death occurred, on the date stated above, at 11:10 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

Chronic Myocarditis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) Marvin M. McLean M. D.

, 19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	Apr 24 1929
20 UNDERTAKER: John H Toadvine	ADDRESS 1027 Hanover

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45302

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001

E 45302

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 506 Woodlawn Road ST. 27-53 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alice Patterson Wardlaw

(a) RESIDENCE NO. 506 Woodlawn Road ST.; WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 75? yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 9, 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	10	12	13

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Abbeville (State or country) South Carolina

PARENTS

10 NAME OF FATHER David Lewis Wardlaw

11 BIRTHPLACE OF FATHER (city or town) Abbeville (State or country) S. C.

12 MAIDEN NAME OF MOTHER Sarah Allen

13 BIRTHPLACE OF MOTHER (city or town) Charleston (State or country) S. C.

14 Informant L. Wardlaw Miles

(Address) 506 Woodlawn Road

15 FILED APR 23 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22 1929

17 I HEREBY CERTIFY, That I attended deceased from March 8, 1929, to April 21, 1929, that I last saw h alive on Apr. 21 1929 and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows: Multiple Neuritis 1 mo 13 days Lobar Pneumonia

CONTRIBUTORY (Secondary) Senile Arteriosclerosis (duration) yrs. mos. 1 ds.

(duration) 2+ yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs.

(Signed) M. Gibson Forlaw, M. D.

4/22 1929 (Address) 4822 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount — DATE OF BURIAL April 23rd 1929

20 UNDERTAKER Henry W. Perkins & Son Co. — ADDRESS McCulloh & Orchard Sts.

Spec.—1-12-23—M&T—500 Blks.

Calimese

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45303

CERTIFICATE OF DEATH

101-001

E 45303 REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Provident Hospital

CITY OF BALTIMORE: (No.) Division ST., 16-22 (WARD)

2-FULL NAME Mrs Alice Calimese

(a) RESIDENCE NO. 1423 Lauders ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William Calimese

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: 27 — Months: — — Days: — — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balt. Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Self.

(Address)

15 Filed ..., 19... HANSON JONES, M. D.

Per ...

Registrar

R23-1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 20 1929

17 I HEREBY CERTIFY, That I attended deceased from Apr 17, 1929, to Apr 20, 1929.

That I last saw h[illegible] alive on Apr 20, 1929

and that death occurred, on the date stated above, at 9 45 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Undetermined

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Blood Culture

(Signed) [illegible] M. D.

, 19 (Address) Provident Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn cemetery

DATE OF BURIAL: Apr 23 19 29

20 UNDERTAKER: Thomas E. Kelson

ADDRESS: 1303 Pressman

TION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 45304

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-00

E 45304

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1625 Ellsworth St., 8-17 Ward)

2-FULL NAME Robert Carter

(a) RESIDENCE NO. 1625 Ellsworth St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M.	C	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Carter

6 DATE OF BIRTH (month, day, and year) Mar 5 1889

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	40	1	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. Odd

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Va

PARENTS

10 NAME OF FATHER Dallas Carter

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Dallie Carter

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Mary Carter

(Address) 1625 Ellsworth

15 Filed....., 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 20/29 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to n/k death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Lobar Pneumnia

(duration) .....yrs. .....mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) J. T. Carter M. D.

(Coroner)

4/23/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

IS LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Mt. Calvary	Apr. 23 1929

20 UNDERTAKER Mrs. P. A. Elliott ADDRESS 1723 Arlington Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

APR 23 1929

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45305

CERTIFICATE OF DEATH.

x 188-203

E 45305
REGISTERED NO.

1-PLACE OF DEATH Pronounced dead at

City of BALTIMORE: (No. Balto City Hos. St. 16-37 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph Gilbert

(a) RESIDENCE NO. Joppa Balto Co St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
about	12			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Bel Harford Co 1917 (Address) 700 E Chase St

PARENTS

10 NAME OF FATHER Charles Gilbert

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Harford Co

12 MAIDEN NAME OF MOTHER Willie Stevenson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Harford Co

14 Informant Olive Thurston

(Address) Joppa Md

15 Filed APR 23 1929 HERBERT JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture Base of Skull Contusions Accident (Balto Co)

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) James M Kenton M. D.

(Coroner)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Foster Hill Md

Date of Burial Apr 25 1929

20 UNDERTAKER Howard K McComas

ADDRESS Abingdon

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

Dr D Miller 1500 Broadway

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45306

CERTIFICATE OF DEATH

90 E 45306

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3235 Brehms Lane ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sylvia E. Kane

(a) RESIDENCE NO. 3235 Brehms Lane ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas E. Kane

6 DATE OF BIRTH (month, day, and year) Feb 6, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	2	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Thomas Linton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sylvia Simmons

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Miss Mary E. Kane

(Address) 3235 Brehms Lane

15 Filed APR 23 1929 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21, 1929

17

I HEREBY CERTIFY, That I attended deceased from June 8, 1928, to April 21, 1929, that I last saw her alive on 4-21, 1929 and that death occurred, on the date stated above, at 10 m.

The CAUSE OF DEATH* was as follows:

Aortic Regurgitation

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Myocardial degeneration

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) David Miller, M. D.

4/22, 1929 (Address) 1500 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL 4/24 1929

20 UNDERTAKER D. Lum Cook

ADDRESS 1216 Park

Cor.—10-10-29—A Co.—100 Bks.

E 45307

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74 1001
74 E 45307

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Joseph Hospital St. 8-17 Ward)

2-FULL NAME Edner L. Story

(a) RESIDENCE NO. 1430 N. Broadway St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Widower

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Laura V. Story

6 DATE OF BIRTH (month, day, and year) Apr 8/1850

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	73	0	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Inspector of
(b) General naturo of industry, business, or establishment in which employed (or employer) Plbg & Manhol Building
(c) Name of employer City of Baltimore

9 BIRTHPLACE (city or town)
(State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Raymond M Story
(Address) 1430 N Broadway

15 Filed ..... 19.. C. Ellison Jones M. D. Registrar

APR 23 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 22/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to insi death on the day stated above.

The CAUSE OF DEATH* was as follows:

Aoplexy

(duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary)

(duration) ..yrs. ..mos. ..ds.

18 Where was disease contracted If not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Cain, M. D.

4/22/29 (Address) 508 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Mausoleum

DATE OF BURIAL Apr 25 1929

20 UNDERTAKER Robt J Kinsley

ADDRESS 1 E Pratt

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45308

E 45308

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. South Baltimore General Hospital Ward) 6-4

2-FULL NAME Daniel McCleas. (C)

(a) RESIDENCE NO. 1715 Mullikin St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Do not know.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	65	//////////		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Do not know.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant J. C. Stert.
(Address) Foot of Clinton st.

15 [illegible] C. HARRISON JONES, M.D.
Registrar

APR 23 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19, 1929 92

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Organic disease of the heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Balto Fidelity Warehouse Co. St. Clinton

Did an operation precede death? Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Otto M. Steinhardt, M. D.

4/22, 1929 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pasbury cemetery	April 23 1929
20 UNDERTAKER Edward Bryan	ADDRESS 1631 Orleans St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 45309

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 45309

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hosp St. 12-30 Ward)

2-FULL NAME Charles Frey

(a) RESIDENCE NO. 612 Burgundy St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: Col

5 Single, Married, Widowed or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: no

6 DATE OF BIRTH (month, day, and year): Sept 21-1821

7 AGE: Years 7 | Months 7 | Days — | IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town): Norfolk Va
(State or country)

PARENTS

10 NAME OF FATHER: Chas Frey

11 BIRTHPLACE OF FATHER (city or town): Va
(State or country)

12 MAIDEN NAME OF MOTHER: Lula Macon

13 BIRTHPLACE OF MOTHER (city or town): Va
(State or country)

14 Informant: Lola Frey
(Address): 612 Burgundy

Filed ... 19... H. LAWSON JONES, M. D., Registrar

By ...

R 231929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): Apr 21st 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ... (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said Autopsy & Inquiry, (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) ... yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): None - (Autopsy Proved)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? 612 Burgundy

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Yes

(Signed) Ellerslie Coroner, M. D.

(Address) Apr 30th 1929

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary Cemtery

DATE OF BURIAL: 4/24 1929

20 UNDERTAKER: Walter B. Griggs

ADDRESS: 134 W Hamburg St

Spec.–7-17-26—A Co.—200 Bks.

E 45310

HEALTH DEPARTMENT—CITY OF BALTIMORE

1-001

E 45310

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH Mercy Hospital

City of BALTIMORE: (No. 9-19 St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stiffler, E. LeRoy

(a) RESIDENCE NO. 125 East North Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. E. L. Stiffler

6 DATE OF BIRTH (month, day, and year) ~~March~~ June 13, 1883

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
	~~46~~ 45	10	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Undertaker 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER W. H. Stiffler

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Ida J. L. Stiffler

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Roland L. Fisher

(Address) 125 E. North Ave.

15 [illegible] C. H. [illegible] M. D.

Registrar

PR231929

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 April 22, 1929

17 I HEREBY CERTIFY, That I attended deceased from 4-20, 1929, to 4-22, 1929, that I last saw h[illegible] alive on 4-22-29, 19, and that death occurred, on the date stated above, at 905 a. m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(duration) yrs. mos. 2 0 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood Culture

(Signed) M Carey, M. D.

4-22-1929 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge — Date of Burial April 24, 1929

20 UNDERTAKER Wm. F. Keller — ADDRESS 329 E. North Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 45311 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74-001

E 45311

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 618. W. North av ST. 13-20 WARD)

2-FULL NAME Stephen Hart.

(a) RESIDENCE NO. 618. W. North av ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White.

5 ~~Single~~, Married, ~~Widowed~~, ~~or Divorced~~. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary. Hart

6 DATE OF BIRTH (month, day, and year): 1860

7 AGE: 68 69 Years | Months | Days | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter 015

(b) General nature of industry, business, or establishment in which employed (or employer): B & O.

(c) Name of employer: P R Co

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Alex. Hart.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Ann Andrew

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mary J. Hart

(Address): 618 W. North av

15 C. HAMPSON JONES, M. D.

Registrar

16 Filed: 4-27 1929

231929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 22 1929

17

I HEREBY CERTIFY, That I attended deceased from April 12, 1929, to April 21, 1929,

that I last saw him alive on April 21, 1929

and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs mos 1 ds.

CONTRIBUTORY (Secondary): Paralysis right side

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? No

(Signed) Haugh Forsythe, M. D.

4-23, 1929 (Address) 424 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: April 24 1929

20 UNDERTAKER: Geo. L. Ruth

ADDRESS: 1725 Harford av

TION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45312

HEALTH DEPARTMENT—CITY OF BALTIMORE

90. E 45312

CERTIFICATE OF DEATH

BALTIMORE CITY HOSPITALS

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., 4-6 WARD)

2—FULL NAME Rebecca Wilson

(a) RESIDENCE NO. 214 Hunter ..... ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: James Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Miranda

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Records of

(Address) BALTIMORE CITY HOSPITALS

15 Filed ..... 19..... Registrar

231528 C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 20, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 19, 29, 19..... to April 20, 19 29

that I last saw her alive on April 20, 19 29

and that death occurred, on the date stated above, at 2:45 A. m.

The CAUSE OF DEATH* was as follows:

Chr. myocarditis

myocardial insufficiency

(duration) ..... yrs. 4 mos. ..... ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Physical exam & Lab

(Signed) Warwick M. Clough M. D.

, 19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	4-24 19 29
20 UNDERTAKER George T. A. Gibson	ADDRESS 1736 Druid Hill Ave

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45313

CERTIFICATE OF DEATH.

E 45313

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. ..... ST., 17-10 WARD)

REGISTERED NO. 161

(If death occurred in a hospital or institution, give its NAME instead of street and number.) Johns Hopkins Hospital

2-FULL NAME Baby Kendrick

(a) RESIDENCE NO. 2302 Jefferson St. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 1, 1929

7 AGE Years ..... Months ..... Days one If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... ind

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... (State or country) Md.

PARENTS

10 NAME OF FATHER William Kendrick

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Md.

12 MAIDEN NAME OF MOTHER Alice Bowen

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Md.

14 Informant ..... (Address) .....

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April. 1 1929

17 I HEREBY CERTIFY, That I attended deceased from 4-1-29, 19 ..., to 4-1, 19 29, that I last saw ~~him~~ alive on 4-1, 19 29, and that death occurred, on the date stated above, at 8.00 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) ..... M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL ..... DATE OF BURIAL 19

20 UNDERTAKER ..... ADDRESS .....

Filed APR 23 1929 19 C. HAMPSON JONES, M. D. Registrar

By 9505 RRP

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45314

E 45314

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1421 Ward · ST. 21-28 WARD

REGISTERED NO. 161

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Beasley.

(a) RESIDENCE NO. 1421 Ward ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 4/20/29

7 AGE — Years — Months — Days: 2 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Maryland.

PARENTS

10 NAME OF FATHER Frederick Houston.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland.

12 MAIDEN NAME OF MOTHER Eva Beasley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant (Address)

15 Filed 19 Registrar

C. HAMPSON JONES M. D.

231929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/22 1929

17 I HEREBY CERTIFY, That I attended deceased from 4/20, 1929, to 4/21, 1929, that I last saw her alive on 4/21, 1929, and that death occurred, on the date stated above, at 4 a.m.

The CAUSE OF DEATH* was as follows:

Prematurity (2 mths)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

(Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

APR 23 1929

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 45315

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45315

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1147 Hanover ST. 23-31 (WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilhelmina Mueller

(a) RESIDENCE NO. 1147 Hanover ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ludwig Mueller

6 DATE OF BIRTH (month, day, and year): March 15 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	1	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 637

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Ambrose Mueller

11 BIRTHPLACE OF FATHER (City or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Germany.

14 Informant: Ludwig Mueller

(Address) 1147 Hanover St

15 2 3 1929 C. HAMPSON JONES, M. D. Registrar

Par

TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-21st 1929

17 I HEREBY CERTIFY, That I attended deceased from 4-11, 1929, to 4-21, 1929,

that I last saw h[illegible] alive on 4-21 29,

and that death occurred, on the date stated above, at 8 05 A.M.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis & Chronic endocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John A. Schmunk M. D.

, 19 (Address) 1337 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross & A Co — DATE OF BURIAL: 4-24th 1929

20 UNDERTAKER: E & B Harle — ADDRESS: 115 E West St.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45316

CERTIFICATE OF DEATH

109-002 E 45316

1—PLACE OF DEATH Mia Memorial Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. 3 W Pl ST. 8-11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Floretta M Smith

(a) RESIDENCE NO. 2815 E Preston ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles J Smith.

6 DATE OF BIRTH (month, day, and year): May 1, 1887.

7 AGE — Years: 41 | Months: 11 | Days: 22 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none 027

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): West Va.

PARENTS

10 NAME OF FATHER: Wm H Bode

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Rachel Yankgon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): West Va.

14 Informant: Hospital Records

(Address)

15 Filed ..., 19... Registrar

R 23 1929 C. HAMPSON JONES, M. D.

Past

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 22, 1929

17 I HEREBY CERTIFY, That I attended deceased from Apl. 19th, 1929, to Apl 22, 1929, that I last saw her alive on Apl 22", 1929, and that death occurred, on the date stated above, at 9:25 a. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation following operation

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Apl 22 1929

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H C Davis M. D.

. 19 (Address) 405 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pine Grove Cem. Union W. Va

DATE OF BURIAL: April 24 1929

20 UNDERTAKER: George Schilling & Sons

ADDRESS: 1125 E Monument St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45317

CERTIFICATE OF DEATH

101-001

E 45317
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2005 E. 32nd St St., 9-46 Ward)

2-FULL NAME John A. Kerney

(a) RESIDENCE NO. 2005 E. 32nd St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	widower

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary F. Kerney

6 DATE OF BIRTH (month, day, and year) July 12/1847

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	81	9	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Haberdasher
(b) General nature of industry, business, or establishment in which employed (or employer) Self
(c) Name of employer

9 BIRTHPLACE (city or town) Cumberland, Md.
(State or country)

PARENTS

10 NAME OF FATHER Martin Kerney

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Murray

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Elmer A. Kerney
(Address) 2005 E. 32nd St

15 Filed ..... 19.. C. HAMPSON JONES, M. D., Registrar

R 231929 Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 22/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Collins, M. D.

4/23/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	April 25 1929
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1026 E. Monument

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45318 E 45318

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH

CITY OF BALTIMORE: (No 2802 W. Mulberry St.) 10-69 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Pearce

(a) RESIDENCE NO. 2802 W. Mulberry ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William M. Pearce

6 DATE OF BIRTH (month, day and year): June 24, 1892

7 AGE — Years: 36 — Months: 11 — Days: 27 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: William E Bowell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mary Severe

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: William M. Pearce
(Address): 2802 W. Mulberry st.

15 Filed: 1-31-29 C. HAMPSON JONES, M. D. Registrar

Par. CHH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): Feb. 21 1929

17

I HEREBY CERTIFY, That I attended deceased from December 26th, 1928, to April 20th, 1929, that I last saw her alive on April 20th, 1929, and that death occurred, on the date stated above, at 9.40 A. m.

The CAUSE OF DEATH* was as follows:

Cancer of uterus, with metastases in bladder, small intestines and large intestines.

(duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Cardiac dilatation: 36 hours.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 601 East Twenty-seventh St.

Did an operation precede death? Yes. Date of Nov. 17th, 1928.

Was there an autopsy? No.

What test confirmed diagnosis? Clinical examination.

(Signed) Chas. S. Rohrer, M. D.

, 19 (Address) 2814 Ailsa Avenue.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem.

DATE OF BURIAL: Apr. 29 1929

20 UNDERTAKER: Easton Sons

ADDRESS: Ellicott City

TION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45319 74-01 E 45319

CERTIFICATE OF DEATH.

REGISTERED NO. 12-51

1-PLACE OF DEATH

City of BALTIMORE: (No. 207 W. 25th St. 2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Susan Hutchins

(a) RESIDENCE NO. 207 W. 25th St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. — mos. — ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	widowed.

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of George Henry Hutchins

6 DATE OF BIRTH (month, day, and year) April 28-1869.

7 AGE	Years	Months	Days 24	IF LESS than 1 day.....hrs. or.....min.
	59.	11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work house-wife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Shenandoah Co.

(State or country) Virginia

PARENTS

10 NAME OF FATHER Robert S. Mowery

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Shenandoah Co, Va.

12 MAIDEN NAME OF MOTHER ? Spitler

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Shenandoah Co, Va.

14 Informant Friend Gain

(Address) 207 W. 25th St.

15 Filed APR 29 1929 C. HAMPSON JONES, M. D. Registrar

Per APR.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22-1929.

17

I HEREBY CERTIFY, That I attended deceased from April 1, 1927, to April 22-, 1929, that I last saw him alive on April 22-, 1929, and that death occurred, on the date stated above, at 10:00 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemmorhage:

(duration) 4 hours. yrs. mos. ds.

CONTRIBITORY (Secondary) Hypertension

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? physical signs

(Signed) Chester Riland, M. D.

4-23-1929 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Date of Burial April 25 1929.

20 UNDERTAKER G. Thompson Son ADDRESS 361 Chestnut Ave

IF DEATH IN PLAIN CASES, SO THAT IT MAY BE PROPERLY CLASSIFIED. EXACT STATEMENT OF OCCUPATION IS very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 45320

CERTIFICATE OF DEATH

E 45320

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3510 3rd St Brooklyn ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harry L. Coe

(a) RESIDENCE NO. 3516 3rd St ST. 11 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~ yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Son

6 DATE OF BIRTH (month, day, and year) July 11, 1927

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	1	9	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work)

(b) General nature of industry, business, or establishment in which employed (or employer) old.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Millard Coe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Bertha Linke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs Bertha Coe

(Address) 3510 3rd St Brooklyn

15 Filed ..... 19 C. HAMPSON JONES, M. D. Registrar

APR 23 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22 1929

17 I HEREBY CERTIFY, That I attended deceased from April 19, 1929, to April 22, 1929

that I last saw h alive on April 22, 1929

and that death occurred, on the date stated above, at 9:30 a m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Primary) (duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Convulsions (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. L. Campbell M. D.

April 22 1929 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	April 24 1929
20 UNDERTAKER Chas. L. Stevens	ADDRESS 1308 E Fort Ave

important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45321

CERTIFICATE OF DEATH.

3-4 129

E 45321

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 810 S Bond St. ____ Ward)

2-FULL NAME Albina Sherrick

(a) RESIDENCE NO. 810 S Bond St. ____ Ward ____

(Usual place of abode)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ da. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ da.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ____

6 DATE OF BIRTH (month, day, and year): May 1 1926

7 AGE: Years 3 Months 1 Days 23 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer

9 BIRTHPLACE (city or town): Balto City

(State or country)

PARENTS

10 NAME OF FATHER: Joseph Sherrick

11 BIRTHPLACE OF FATHER (city or town) ____

(State or country): Penn.

12 MAIDEN NAME OF MOTHER: Dorothy Path

13 BIRTHPLACE OF MOTHER (city or town) ____

(State or country): Mississippi

14 Informant: Dorothy Sherrick

(Address): 810 S Bond St

C. HAMPSON JONES, M. D.

19 ____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 23 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Purulent Nephritis

(duration) 2 yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) ____

(duration) ___ yrs. ___ mos. ___ ds.

(Signed) James M. Fenton M. D.

(Coroner)

4 23 1929 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ___ yrs., ___ mos., ___ ds. In the State ___ yrs., ___ mos., ___ ds.

Where was disease contracted, if not at place of death? ____

Former or usual residence ____

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Date of Burial April 25 1929

20 UNDERTAKER: John M Weber ADDRESS: 1114 Chester

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

231929

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45322

CERTIFICATE OF DEATH

90 E 45322

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

CITY OF BALTIMORE: (No. 1-3 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Michael Olkowski

(a) RESIDENCE NO. 245 S. Madiera ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katie Olkowski

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
About 61 (over)			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Joe Olkowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mathilda ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Records of (Address)

15 Filed APR 23 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 2, 19 29 to April 22, 19 29, that I last saw him alive on April 22, 19 29 and that death occurred, on the date stated above, at 1:05 P m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis
myocardial insufficiency

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Marvin M. Kline M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	April 25 1929

20 UNDERTAKER ADDRESS

John W Welsh 3324 Chester

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45323

CERTIFICATE OF DEATH

E 45323

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. So. Balto. Gen Hosp ST. 4 32 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Arthur Dunson

(a) RESIDENCE NO. Brooklyn, P.O. Md ST., A.A. Co. Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 7 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day and year): Aug 27 1912

7 AGE: Years 16 | Months 7 | Days 24 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Morton Dunson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Grace Jarvis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Thornton Dunson

(Address) Belly Grove Md

15 [illegible] M. D.

Registrar

R 24 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/21/29

17

I HEREBY CERTIFY, That I attended deceased from 4/21, 19 29, to 4/21, 19 29,

that I last saw h/ alive on 4/21, 19 29

and that death occurred, on the date stated above, at 6.50 p m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis,

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Pneumonitis.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Brooklyn, P.O. Md,

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Autopsy

(Signed) F. Sutton Wilcox M. D.

4/22, 1929 (Address) So Balto Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Fairview Cem. DATE OF BURIAL: April 24 1929

20 UNDERTAKER: Samuel Hensley ADDRESS: 1718 Bridle

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45324 — 74-001 — E 45324

CERTIFICATE OF DEATH

1—PLACE OF DEATH — REGISTERED NO. 1521

CITY OF BALTIMORE: (No. 1829 N Mount ST. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Martha MacKall

(a) RESIDENCE NO. 1829 N Mount ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of David MacKall

6 DATE OF BIRTH (month, day, and year) 6-20-1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55-6	11	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Henson Waters

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Louisa Bryant

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant David MacKall

(Address) 1829 N. Mount st

15 Filed APR 24 1929, 19 — C. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21/29

17 I HEREBY CERTIFY, That I attended deceased from April 18, 1929, to April 21, 1929, that I last saw her alive on April 20, 1929 and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. W. Ward, M. D.

, 19 (Address) 2005 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary — DATE OF BURIAL 4-25 1929

20 UNDERTAKER George D. A. Gibson — ADDRESS 1735 Druid Hill Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45325

CERTIFICATE OF DEATH

90 ✓

E 45325

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2501 E Federal ST., 8-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Catherine L. Scott

(a) RESIDENCE NO. 2501 E. Federal ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. — mos. — ds. How long in U. S., if foreign birth? Life mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas J. Scott.

6 DATE OF BIRTH (month, day, and year) Not known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about	85	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Matthew Leonard

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Bridget Nicholson

11 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant Mrs. Andrew Fauthiber

(Address) 2501 E. Federal St

15 Filed APR 24 1929 HAYDEN JENKINS, D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22nd 1929

17 I HEREBY CERTIFY, That I attended deceased from April 21, 19 29 to April 22, 19 29.

that I last saw her alive on April 22, 19 29

and that death occurred, on the date stated above, at 8.45 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Acute decompensation of Heart Disease

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? None

(Signed) Thos. F. A. Stevens, M. D.

4/23, 19 29 (Address) 2876 Hayford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	Apr. 25 1929
20 UNDERTAKER	ADDRESS
Henry Hoeck Sons, Inc.	1301 E Eager St

Spec.—2-29-28—L. F. S.—500 Bks.

E 45326

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

162 E 45326

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1553 Aliceston ST., 9-46 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph Henry Rice

(a) RESIDENCE NO. 1553 Aliceston ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Apr 23 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 8 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant- ~~one~~

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Daniel H. Rice

11 BIRTHPLACE OF FATHER (city or town) Forge
(State or country) Pa.

12 MAIDEN NAME OF MOTHER Philomenia Burkhart

13 BIRTHPLACE OF MOTHER (city or town) Braddock
(State or country) Pa.

14 Informant Daniel H Rice

(Address) 1553 Aliceston

15 Filed APR 24 1928 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 23 1929

17 I HEREBY CERTIFY, That I attended deceased from Apr 23, 1929, to Apr 23, 1929, that I last saw h[illegible] alive on Apr 23, 1929, and that death occurred, on the date stated above, at 3:35 p.m.

The CAUSE OF DEATH* was as follows:

Atelectasis

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? (duration) yrs. mos. ds.

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas Fu Sieries M. D.

Apr 27, 1929 (Address) 2818 Hillsdale Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery DATE OF BURIAL April 24 1929

20 UNDERTAKER Henry Hoeck Sons, Inc. ADDRESS 1301 E Eager St

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45327

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 ✓ E 45327

1—PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1101 N. Eden ST. 10-C WARD)

2—FULL NAME Emma C. Freeland

(a) RESIDENCE NO. 1101 N. Eden ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): widow

.a If married, widowed, or divorced HUSBAND of (or) WIFE of: George Freeland

6 DATE OF BIRTH (month, day, and year): Dec. 21, 1868

7 AGE — Years: 60 — Months: 4 — Days: 1 — If LESS than 1 day, hrs. or min.:

8. OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none 60

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Louis Grube

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Augusta Cook

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

11 Informant: Caroline Abbott

(Address) 707 E. University Pkwy

15 Filed APR 24 1929 C. HAMPSON JONES, M. D. Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 23, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 21st, 1927, to April 21st, 1929, that I last saw her alive on April 21st, 1929, and that death occurred, on the date stated above, at 12:10 A.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 47 yrs. — mos. — ds.

CONTRIBUTORY (Secondary): asthenia

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Sputum exam.

(Signed) Gordon Wilson, M. D.

, 19 (Address) 715 Park Av. Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cem.	April 24 1929
20 UNDERTAKER: John O. Mitchell & Sons	ADDRESS: 1900 Eutaw St.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45328

CERTIFICATE OF DEATH

E 45328

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE, (No. 3814 Hudson ST. 76-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frances Brendel

(a) RESIDENCE NO. 3814 Hudson ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of William Brendel

6 DATE OF BIRTH (month, day, and year) Oct 1-1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	6	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Charles Decker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Jaecksch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Amelia Brendel

(Address) 3814 Hudson St

15 Filed ... 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec. 10th, 1928, to April 22nd 1929, that I last saw her alive on April 22nd, 1929 and that death occurred, on the date stated above, at 9.20 P. m.

The CAUSE OF DEATH* was as follows:

Pernicious Anaemia

(duration) — yrs. 9 mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Hemoglobin & Urinary

(Signed) David W. Jones, M. D.

4/23/1929 (Address) 1011 N. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery

DATE OF BURIAL April 26 1929

20 UNDERTAKER George W Zirkle

ADDRESS 1737 E Eager st

Important. See instructions on back of this certificate.

APR 24 1929

Cor.—12-9-25—A Co.—200 Bks.

E 45329

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11-004

E 45329

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital St. 10-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James A. Finnegan

(a) RESIDENCE NO. 600 E. Biddle St Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
M-	W-	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Clara Finnegan

6 DATE OF BIRTH (month, day, and year) July 20 - 1872

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	56	9	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Printer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) N.Y. City

(State or country)

PARENTS

10 NAME OF FATHER Jas. A. Finnegan, Sr.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Fagan

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Mrs. J. Finnegan

(Address) 528 E. 23rd St.

15 Filed APR 24 1929 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23, 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Influenza

(duration) yrs. mos. ds.

(Signed) Eugene Zeller M. D.

(Coroner)

4/24, 1929 (Address) 2939 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Vincent Cemetery Date of Burial 4/25 1929

20 UNDERTAKER Chas. Frank & Son ADDRESS 1811 Mc Henry Ave

OF DEATH is path terms, so that it may be properly classified. PART Statement of VALUATION IS very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 45330 HEALTH DEPARTMENT—CITY OF BALTIMORE E 45330

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1631 N. Caroline (St.) 8-17 (Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine L. Dunn

(a) RESIDENCE NO. 1631 N. Caroline ST. ..... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James H. Dunn

6 DATE OF BIRTH (month, day, and year): March 12-1864

7 AGE — Years: 65 — Months: 1 — Days: 10 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Dennis Hargan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Catherine Hargan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: James H. Dunn

(Address) 1631 N. Caroline St.

Filed APR 24 1929 HAMPSON JONES, M. D. Registrar

By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 22nd 1929

17 I HEREBY CERTIFY, That I attended deceased from Apl. 16 1929 to Apl. 22 1929

that I last saw her alive on Apl. 21 1929

and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 1 Yr. Intermittent

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Benj. D. Hampson, M. D.

4/23 1929 (Address) 1246 N. Carlton St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: 4/25 1929

20 UNDERTAKER: Chas. E. Evans & Son — ADDRESS: 11 S. Mt. Royal Ave

ATION is very important See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45331

CERTIFICATE OF DEATH

46 E 45331

1—PLACE OF DEATH Home

REGISTERED NO. 24-31

CITY OF BALTIMORE: (No. 1130 Hanover ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Sophia Murr

(a) RESIDENCE NO. 1130 Hanover St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. 11 mos. 21 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	white	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas E. Murr.

6 DATE OF BIRTH (month, day, and year) 5-1-1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	11	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Mrs Murr

(Address) 1130 Hanover St.

15 R 24 1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-22-29

17 I HEREBY CERTIFY, That I attended deceased from Nov 1, 1928, to Apr 22, 1929, that I last saw h[illegible] alive on Apr 22, 1929 and that death occurred, on the date stated above, at 7 20 p m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cervix

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Gen Carcinomatosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) W W Walker, M. D.

, 19 (Address) 910 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Cedar Hill — DATE OF BURIAL 4/28 1929

20 UNDERTAKER J. Geo McAuley — ADDRESS 130 E Fay

Spec.—2-29-28—L. F. S.—500 Bks.

45332

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45332

CERTIFICATE OF DEATH

1—PLACE OF DEATH JOHNS HOPKINS HOSPITAL REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Albert McNamara

(a) RESIDENCE NO. Fairmount Md ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Cora C. McNamara

6 DATE OF BIRTH (month, day, and year) 2/28/1864

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
65	1	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mariner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Patrick McNamara

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Maryanna Cox

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 APR 24 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23-1929

17

I HEREBY CERTIFY, That I attended deceased from Mar. 3, 1929, to April 23, 1929, that I last saw h[illegible] alive on April 23, 1929 and that death occurred, on the date stated above, at 2 45 p. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) (?) yrs. mos. ds.

CONTRIBUTORY (Secondary) cystitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) L. B. Smith, M. D.

. 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fairmount Md — DATE OF BURIAL Apr 23 1929

20 UNDERTAKER John Mercier — ADDRESS 208 Eream

Spec.—2-29-28—L. F. S.—500 Bks.

E 45333

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 E 45333

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 6-17

CITY OF BALTIMORE: (No. 2015 E Lafayette Ave WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret L Wilder

(a) RESIDENCE NO. 2015 E Lafayette Ave WARD
(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. 11 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or ~~Divorced~~, (write the word)
Female	White	Single

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 24, 1928

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER William Wilder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md

12 MAIDEN NAME OF MOTHER Mary R Rachford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant William Wilder

(Address) 2015 E Lafayette Ave

15 Filed Apr 24 1929 19 C. BANCROFT JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22 1929

17 I HEREBY CERTIFY, That I attended deceased from Apr 19, 1929, to Apr 22, 1929, that I last saw h.. W alive on Apr 22, 1929 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia
Primary
(duration) 3 yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jacob Fisher, M. D.

4/23, 1929 (Address) 1823 N Wash Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	April 24, 1929
20 UNDERTAKER	ADDRESS
Robt L Turner & Son	442 N Broadway

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45334

CERTIFICATE OF DEATH

E 45334

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. UNION MEMORIAL HOSP. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME WILLIS EDWARD EDWARDS

(a) RESIDENCE NO. 142 N. BROAD ST., WARD LANCASIER, PA.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	MARRIED

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Lin Brown

6 DATE OF BIRTH (month, day, and year) Jan. 28, 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	36	2	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ELECTRIC WORK

(b) General nature of industry, business, or establishment in which employed (or employer) Ore

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) PENNA.

PARENTS

10 NAME OF FATHER JESSE EDWARDS

11 BIRTHPLACE OF FATHER (city or town) (State or country) PENNA

12 MAIDEN NAME OF MOTHER MARY ESKMAN

13 BIRTHPLACE OF MOTHER (city or town) (State or country) PENNA

14 Informant D. E. EDWARDS

(Address) Vital Records

15 Filed C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/24/29

17 I HEREBY CERTIFY, That I attended deceased from April 4, 1929, to APRIL 24, 1929, that I last saw h.[illegible] alive on APRIL 24, 1929 and that death occurred, on the date stated above, at 1:45 P. m.

The CAUSE OF DEATH* was as follows:

BANTI'S DISEASE

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cirrhosis of liver atrophy of left kidney (duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? Lancaster Pa.

Did an operation precede death? Yes Date of 4/18/29

Was there an autopsy? Yes (partial)

What test confirmed diagnosis? Autopsy.

(Signed) A C Thompson, M. D.

Apr. 1929 (Address) Union Memorial Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lancaster, Pa	Apr 1929
20 UNDERTAKER H. J. Dickey & Sons	ADDRESS Lancaster

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45335

CERTIFICATE OF DEATH.

108 E 45335

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2434 Lanvale Ave St. 20-64 Ward)

2-FULL NAME Edward Olin Dunsley

(a) RESIDENCE NO. 2434 Lanvale Ave St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catharine Dunsley.

6 DATE OF BIRTH (month, day, and year) Nov 12 1903

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	25	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lunch Room Proprietor

(b) General nature of industry, business, or establishment in which employed (or employer) 886

(c) Name of employer

9 BIRTHPLACE (city or town) Sussex Co.

(State or country) Maryland.

PARENTS

10 NAME OF FATHER Walter T. Dunsley.

11 BIRTHPLACE OF FATHER (city or town) Sussex Co.

(State or country) Md.

12 MAIDEN NAME OF MOTHER Anna E. Jones

13 BIRTHPLACE OF MOTHER (city or town) Sussex Co.

(State or country)

14

Informant Catharine Dunsley

(Address) 2434 Lanvale Ave.

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22 1929.

17

I HEREBY CERTIFY, That I attended deceased from April 19, 1929, to April 22, 1929, that I last saw h.im alive on April 22, 1929, and that death occurred on the date stated above, at 10:40 P. m.

The CAUSE OF DEATH* was as follows:

Lindwig's Angina

(duration) .....yrs. .....mos. 5 ds.

CONTRIBUTORY (Secondary) Edema of glottis

(duration) .....yrs. 4 hours mos. .....ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of.....

Was there an autopsy? no

What test confirmed diagnosis? Physical signs & bacteriological test:

(Signed) Chester Ruland, M. D.

4-23-1929 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem. Date of Burial 4/25/29 19

20 UNDERTAKER Geo. Lenhardt & Son ADDRESS 209 E. Baltimore St.

OF DEATH in plain terms, so that it may be properly classified. Every statement of OCCUPATION is very important. See instructions on back of certificates.

124525 E. Parker Jones, M. D.

Cor.—10-10-29—A Co.—100 Bks.

E 45336

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1822

E 45336

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Floating in the water at

City of Baltimore: (No.) Westport dump. St. 25-3 (Ward)

2-FULL NAME Unknown.(C)

(a) RESIDENCE NO. Do not know. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Do not know.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	40	---------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Do not know.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Police Report S.D.
(Address)

15 Filed ..... 19.... C. Hamilton Jones, M. D.
Registrar

APR 24 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Body found April 17, 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning.

Probably accidental.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) [illegible], M. D.

4/22, 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY

DATE OF BURIAL ....19....

20 UNDERTAKER Commissioner Health

ADDRESS

APR 24 1929

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45337

CERTIFICATE OF DEATH

182 E 45337

1-PLACE OF DEATH Found floating in the water

City of Baltimore: (No. off Fort McHenry. St. 24-35 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Unknown.(C)

(a) RESIDENCE NO. Do not know. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Do not know.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	40	----------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Do not know.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Police Report. S.D.
(Address)

Date APR 24 1929 [illegible] M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Body found April 17, 1929. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Drowning.
Probably accidental.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) [illegible] M. D.

4/22, 1929 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY

DATE OF BURIAL 19

20 UNDERTAKER Commissioner P. [illegible]

ADDRESS APR 24 192

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45338

CERTIFICATE OF DEATH

198 E 45338

REGISTERED NO.

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hosp. St. 16-23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter W. Warren

(a) RESIDENCE NO. 726 N. Carey St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Blanche Warren

6 DATE OF BIRTH (month, day, and year) 1903

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
26	23			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Blanche Warren
(Address) 726 N. Carey St

Filed APR 24 1929 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 16 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest & Autopsy (Inquest, autopsy or inquiry) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

(Homicide)

Stab wound of heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Stabbed with Butcher knife.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 726 N. Carey

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H. Lee Smith Coroner

Apr 1929 (Address) , M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
PUBLIC CEMETERY	19
20 UNDERTAKER Commissioner of Health	ADDRESS

THE MORGUE APR 24 1929

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 45339

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

188-004

E 45339

1-PLACE OF DEATH

City of BALTIMORE: (No.) Mercy Hosp. St. (Ward) No 37

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Geo. H. Koester

(a) RESIDENCE NO. 105 Janney st St._____ Ward_____

(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mildred Koester

6 DATE OF BIRTH (month, day, and year): Nov. 26-1873

7 AGE — Years: 55 — Months: 4 — Days: 24 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Engine Inspector

(b) General nature of industry, business, or establishment in which employed (or employer): P.R.R.

(c) Name of employer

9 BIRTHPLACE (city or town): Balto. Co.

(State or country)

PARENTS

10 NAME OF FATHER: Frank Koester

11 BIRTHPLACE OF FATHER (city or town)_____

(State or country): Ger.

12 MAIDEN NAME OF MOTHER: Catherine

13 BIRTHPLACE OF MOTHER (city or town)_____

(State or country): Ger.

14 Informant: Mrs. Mildred Koester

(Address): 105 Janney st

Filed APR 24 1929 19__

C. HAMPSON JONES, M. D. Registrar

Per_____

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 26 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Coroner, autopsy or inquiry) find that said deceased came to his death on the date stated above. The CAUSE OF DEATH was as follows:

Multiple Fractures

(duration) yrs. mos. ds.

CONTRIBUTORY (secondary)

(duration) yrs. ds.

(signed) (Coroner) M. D.

(Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the state.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?_____

Former or usual residence_____

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem. Date of Burial: Apr. 14, 29

20 UNDERTAKER: Philip Herwig ADDRESS 2016 Orleans st

OF DEATH is plain terms, so that it may be very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

45340

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 45340

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1416 E Fairmount Ave St.) (5-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Walker

(a) RESIDENCE NO. 1416 Fairmount St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William Walker

6 DATE OF BIRTH (month, day, and year): May 20 1902

7 AGE: Years 27 Months 11 Days — IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): Self

(c) Name of employer: Herself

9 BIRTHPLACE (city or town): Chester Co

(State or country): S. Carolina

PARENTS

10 NAME OF FATHER: Jim Bird

11 BIRTHPLACE OF FATHER (City or town): S. Carolina

(State or country)

12 MAIDEN NAME OF MOTHER: Anna McNeal

13 BIRTHPLACE OF MOTHER (City or town): Chester Co

(State or country): S. Carolina

14 Informant: William Kennedy

(Address) 1416 Fairmount St

APR 24 1929 C. Health Dept., Balto. Md.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

April 20 1929

17 I HEREBY CERTIFY, That I attended deceased from April 16, 19 29, to April 20, 19 29, that I last saw her alive on April 17, 19 29, and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): not known

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? none

(Signed) R V Boerlinger M. D.

, 19 (Address) 1514 E Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: asbury cemetery

Date of Burial: April 24 1929

20 UNDERTAKER: Edward Bryan

ADDRESS 1691 Orleans St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45341

CERTIFICATE OF DEATH.

101-001

E 45341

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 403 N. Greene St. 17-25 Ward)

2-FULL NAME Anthony Cascio

(a) RESIDENCE NO. 403 N. Greene St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 19-1902

7 AGE: 27 Years | Months: 3 | Days: 2 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pressman 13

(b) General nature of industry, business, or establishment in which employed (or employer) _____

(c) Name of employer _____

9 BIRTHPLACE (city or town) Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER Salvatore Cascio

11 BIRTHPLACE OF FATHER (city or town) Italy

(State or country)

12 MAIDEN NAME OF MOTHER Maria Grace Liberto

13 BIRTHPLACE OF MOTHER (city or town) Italy

(State or country)

14 Informant Mother

(Address) 403 N. Greene St

15 Filed _____ 19____ C. HAMILTON [illegible], M. D.

Registrar

R 24 1929

Per _____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-21 1929

17

I HEREBY CERTIFY, That I attended deceased from 4-12, 1929, to 4-21, 1929,

that I last saw him alive on 4-21, 1929,

and that death occurred, on the date stated above, at 3. P. m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) ____ yrs. ____ mos. 16 ds.

CONTRIBUTORY (Secondary) acute Pneumonic Septicemia (duration) ____ yrs. ____ mos. 2 ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? no Date of _____

Was there an autopsy? no

What test confirmed diagnosis? Clinical.

(Signed) S. D'Amarco, M. D.

4-22 1929 (Address) Medical Arts Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — Date of Burial 4/25 1929

20 UNDERTAKER: Geo J Ruth — ADDRESS 1735 Harford ave

OF DEATH in plain terms, so that it may be properly classified. FAILURE TO GIVE INFORMATION AS very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓

E 45342 CERTIFICATE OF DEATH

E 45342 REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of Baltimore: (No. 1215 N. Spring St. 10-13 Ward)

2-FULL NAME William Heintzman

(a) RESIDENCE NO. 1215 N. Spring St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma Heintzman

6 DATE OF BIRTH (month, day, and year) Aug 14/1870

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	58	8	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Sexton 70
(b) General nature of industry, business, or establishment in which employed (or employer) Church North Ave & Aisquith St
(c) Name of employer

9 BIRTHPLACE (city or town) Annapolis, Md.
(State or country)

PARENTS

10 NAME OF FATHER Charles Heintzman

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Emma Heintzman (wife)
(Address) 1215 N. Spring St

15 Filed APR 24 1929 C. HANSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 22/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Probable Chr. Bronchitis

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature], M. D.

4/22/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Calvary Lawn A. A. Co	4-25 1929
20 UNDERTAKER	ADDRESS
Jos. G. Locke	1302 Jefferson

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

Lacotti

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45343 × 100-001 E 45343

CERTIFICATE OF DEATH

1—PLACE OF DEATH — REGISTERED NO. .....

CITY OF BALTIMORE: (No. St. Joseph's Hosp ST., 9-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Boy Lacotti

(a) RESIDENCE NO. Greco, Kasping, Md. ST., ... WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. 0 mos 15 ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Mar 28th 1929

7 AGE Years	Months	Days 24	If LESS than 1 day, ...hrs. or ....min.
		27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto, (State or country)

PARENTS

10 NAME OF FATHER A. J. Lacotti

11 BIRTHPLACE OF FATHER (city or town) Balto. Md, (State or country)

12 MAIDEN NAME OF MOTHER E Dailey

13 BIRTHPLACE OF MOTHER (city or town) Balto, Md (State or country)

14 Informant Mrs. A. J. Lacotti,
(Address) Chesk Park Md.

15 Filed ..... C. Haverly Jones, M. D.
Registrar

R 24 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/22/29.

17 I HEREBY CERTIFY, That I attended deceased from 4/7/29. , 19..... to 4/22/29. , 19.....

that I last saw h.. alive on 4/22/29. , 19.....

and that death occurred, on the date stated above, at 5 30 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth.

..... (duration) ..... yrs. ..... mos. 27 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia,

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no. Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) W. C. Hammerman, M. D.

, 19 (Address) St. Josephs Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Cem.	Nov. 23 1929

20 UNDERTAKER L. C. Trossellbaugh ADDRESS 620 Stat

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45344 E 45344

CERTIFICATE OF DEATH

1—PLACE OF DEATH St Joseph Hospital REGISTERED NO.

CITY OF BALTIMORE: (No.) Caroline & Eutaw (St.) (WARD) 5

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Leon M Blair

(a) RESIDENCE NO. 6 (Usual place of abode) Ellwood Ave ST. 2nd WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 23 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary P Starr

6 DATE OF BIRTH (month, day, and year) Jan 7 87

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	40	3	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Undertaker

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Milton S Starr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Bagley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mary P Starr (Address) Ellwood Ave

15 FILED 24 1929 C. HAMPSON LEWIS, JR. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/23.29

17 I HEREBY CERTIFY, That I attended deceased from 1.3.29, 19..., to 4.23.29, 19..., that I last saw him alive on 4.23.29, 19..., and that death occurred, on the date stated above, at 1.30 p. m.

The CAUSE OF DEATH* was as follows:

Endocarditis of Aortic Valves

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Respiratory Paralysis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 4.23.29

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) N B Hawkins, M. D.

(Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Johns Ellicott City — DATE OF BURIAL April 25 1929

20 UNDERTAKER H M Rouse — ADDRESS 2230 N Bond

Spec.—1-10-21—M&T—1500 Bks.

E 45345 HEALTH DEPARTMENT—CITY OF BALTIMORE E 45345

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4402 Parkmont Ave (ST.) 2-6-42 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leo Leonard

(a) RESIDENCE NO. 4402 Parkmont Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Viola Chaney

6 DATE OF BIRTH (month, day, and year): Feb. 26th 1872

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
57	1	25 27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk U.S.N.

(b) General nature of industry, business, or establishment in which employed (or employer): 009

(c) Name of employer: U. S. Government

9 BIRTHPLACE (city or town) (State or country): Butts Maryland

PARENTS

10 NAME OF FATHER: Leo Leonard Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Virginia Popler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto.

14 Informant: Mrs. Annie Fulmer

(Address) 4402 Parkmont Ave.

15 C. HAMPSON JONES, M. D. Registrar

2 4 1929

PAT

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/23/29 19

17

I HEREBY CERTIFY, That I attended deceased from Feb 26 , 1929 , to April 23 , 1929.

that I last saw him alive on April 20 , 1929 ,

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Gustave Hoff M. D.

4/23, 1929 (Address) Overlea

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery — DATE OF BURIAL: April 26 29

20 UNDERTAKER: Frederick Lassahn & Sons — ADDRESS: Fullerton

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45346

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

28

E 45346

1—PLACE OF DEATH

REGISTERED NO. .....

CITY OF BALTIMORE: (No. 3015 Cresmont Ave. ST. ..... WARD) 12-31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Tipton Bond,

(a) RESIDENCE NO. 3015 Cresmont Ave. ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (write the word)
Male	White	Widowed

6 If ~~married~~, widowed, or ~~divorced~~ HUSBAND of (or) ~~WIFE~~ of Ida Miller Bond.

6 DATE OF BIRTH (month, day, and year) March 4.1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	73	1	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) .....
(State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Thomas Bond,

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Baltimore Co. Md.

12 MAIDEN NAME OF MOTHER Arianna Tipton,

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Baltimore Co. Md.

14 Informant Mrs H. H. Baker

(Address) 3015 Cresmont Ave

15 Filed ..... 19 ..... Registrar

241929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY, That I attended deceased from Feb. 20th, 1929, to Apr. 26th, 1929, that I last saw h. live alive on Apr. 23rd, 1929 and that death occurred, on the date stated above, at 11:20 P m.

The CAUSE OF DEATH* was as follows:

Aortic aneurysm (Aortitis)

(duration) Not Known yrs. mos. ds.

CONTRIBUTORY (Secondary) Syphilis.

(duration) Not Known yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical - Wassermann

(Signed) Geo. H. Kahler, M. D.

, 19 (Address) 28 W 25th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Monkton Md

DATE OF BURIAL 19

20 UNDERTAKER Geo N Little

ADDRESS .....

Spec.—1-10-21—M&T—1500 Bks.

E 45347 HEALTH DEPARTMENT—CITY OF BALTIMORE E 45347

49

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Woman Hospital St. 9-46 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Anna W. Koch

(a) RESIDENCE NO. 2702 Tioley Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of J. Edward Koch

6 DATE OF BIRTH (month, day, and year) June 28 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	9	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitress until last year

(b) General nature of industry, business, or establishment in which employed (or employer) School Board 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Jan 28, Baltimore Md.

PARENTS

10 NAME OF FATHER Schrieber

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Mary Miller (Address) 2702 Tioley Ave

15 C. HAMPSON JONES, M.D. Registrar

16 Filed 19 Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 23 1929

17 I HEREBY CERTIFY, That I attended deceased from April 23, 1929, to April 23, 1929, that I last saw her alive on April 23, 1929, and that death occurred, on the date stated above, at 1:00 P. m.

The CAUSE OF DEATH* was as follows:

Hypernephroma & metastases

(duration) yrs. 6 mos

CONTRIBUTORY (Secondary) Peritonitis (duration) yrs. mos. 2 wks.

18 Where was disease contracted if not at place of death? None.

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) Chas J. Hardyce, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Sulcidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL Apr 26 1929

20 UNDERTAKER Mc Mec J. W. Imfeld Son

ADDRESS 801 W. Fayette

CAUSE OF DEATH must be given in plain English—See instructions on back of certificates. TION is very important.

R 24 1929

Spec.—2-29-28—L. F. S.—500 Bks.

E 45348 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 45348

REGISTERED NO. 12-58

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3129 Guilford Av St., 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Laura Blanche Smith

(a) RESIDENCE NO. 3129 Guilford Av ST., 12 WARD
(Usual place of abode)

Length of residence in city or town where death occurred 59 yrs. 9 mos. 14 ds. How long in U. S., if foreign birth 59 yrs. 9 mos. 14 ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced (write the word) Widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of William H. Smith

6 DATE OF BIRTH (month, day, and year) July 8 1869

7 AGE — Years 59 — Months 9 — Days 14 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Sheeler B. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Waynesboro Penna.

12 MAIDEN NAME OF MOTHER Margaret E. Moore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pittsburgh Penna

14 Informant Mrs. Florence S. Nuidemann (sister)
(Address) 3129 Guilford Av

15 APR 4 1929 C. HARRISON JONES, M. D. Registrar
Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/22/29

17 I HEREBY CERTIFY, That I attended deceased from Nov 11, 1928, to April 22, 1929, that I last saw h alive on April 22, 1929 and that death occurred, on the date stated above, at 9:20 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Papilloedema

(duration) yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Alan R Lemmon M. D.

April 24, 1929 (Address) 918 N Calhoun St Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Waynesboro-Pa. — DATE OF BURIAL April 25, 1929.

20 UNDERTAKER Stewart Mortuary — ADDRESS Balto.

Cor.—12-9-25—A Co.—200 Bks.

E 45349

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1001

E 45349

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins Hosp. St. 26-27 Ward)

2-FULL NAME Elizabeth F. Mundays

(a) RESIDENCE NO. 422 S. Bonsal st. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 16-1927

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	2	0	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.

(State or country)

PARENTS

10 NAME OF FATHER Charles P. Mundays

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va.

12 MAIDEN NAME OF MOTHER Ruby Patton

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va.

14 Informant Charles P. Mundays

(Address) 422 S. Bonsal st

15 Filed C. HARRISON JONES, M.D. Registrar

Per

24 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobular Pneumonia

(Autopsy at Hopkins Hospital)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. H. Falls M. D.

(Coroner)

4/24/29 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Charlottes Va. Date of Burial April 25th 29

20 UNDERTAKER Philip Herwig ADDRESS 2016 Orleans st

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45350

CERTIFICATE OF DEATH.

E 45350

1-PLACE OF DEATH

City of BALTIMORE: (No. Md. General Hosp. St. 1-47 Ward)

REGISTERED NO. 185

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Wallis Crook

(a) RESIDENCE NO. 737 E. 36th st St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Loretta L. Crook

6 DATE OF BIRTH (month, day, and year): Aug 3-1898

7 AGE: Years 30 Months 8 Days 20 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Engineer

(b) General nature of industry, business, or establishment in which employed (or employer): Bethelem steel

(c) Name of employer: Sparrows Point

9 BIRTHPLACE (city or town): Rocksburg Mills

(State or country): Md.

PARENTS

10 NAME OF FATHER: Henry W. Crook

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Md.

12 MAIDEN NAME OF MOTHER: Georgia Cullison

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Md.

14 Informant: Loretta L. Crook

(Address): 737 E. 36th st

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 24 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Coroner, autopsy or inquiry.) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Spine

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Fall on back getting off engine backward

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) T. C. Luck M. D.

(Coroner) Coroner

(Address) April 24

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death? Sparrow Point

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Citre Cem, Randalstown — Date of Burial: April 27/29

20 UNDERTAKER: Philip Herwig — ADDRESS: 2016 Orleans st

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

24 1929

Sp 2-29-28—L. F. S.—500 Bks.

E 45351

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

7+ 001 ✓ E 45351

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2232 Sidney Ave. ST. Westport 25th WARD)

2—FULL NAME Joseph Aaron Abey

(a) RESIDENCE NO. 2232 Sidney Ave ST. Westport 25th WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 3 mos. 25 ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bryndora Albrechtson 1868

6 DATE OF BIRTH (month, day, and year) Jan 29, ~~1929~~

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61	3	25.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tank builder

(b) General nature of industry, business, or establishment in which employed (or employer) Glass Industries

(c) Name of employer Can Lavery Glass Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Joseph Abey.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Ethel Abey

(Address) 2232 Sidney Ave.

15 Filed 24 1929 19 O. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 24, 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb 13th 1929 to Apr 24 1929

that I last saw him alive on Apr 23 1929

and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis & H.B.P.

(duration) yrs 2 mos 11 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis: Clinical signs.

(Signed) Thamuel O Heckler, M. D.

4/24 1929 (Address) Lakeland, Lansdowne P.O. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	4/27 1929
20 UNDERTAKER	ADDRESS
Henry U. Mears & Son	805 N. Calvert

Mullins

Spec.-7-17-26—A Co.—200 Bks.

E 45352

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-801 ✓ E 45352

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Mercy Hospital St., 21-53 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martin J Mullins

(a) RESIDENCE NO. 13 Midvale Rd. Roland Park St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. 6 mos. 12 ds. How long in U. S. if of foreign birth? — yrs. — mos. — ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Marie Dodson

6 DATE OF BIRTH (month, day, and year): Oct. 11, 1882

7 AGE — Years: 46 Months: 6 Days: 12 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Vice Pres. Lee Elec. Co

(b) General nature of industry, business, or establishment in which employed (or employer): 086

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md

PARENTS

10 NAME OF FATHER: Martin J. Mullins

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Ireland

12 MAIDEN NAME OF MOTHER: Catherine Keaffey

13 BIRTHPLACE OF MOTHER (city or town): Baltimore

(State or country): Maryland

14 Informant: Mrs. Marie D. Mullins

(Address): 13 Midvale Road

15 Filed APR 24 1929 C. HARRISON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/22/29

17 I HEREBY CERTIFY, That I attended deceased from 4/5/29, 19..., to 4/22/29, 19...,

that I last saw h/xx alive on 4/22/29, 19...,

and that death occurred, on the date stated above, at 11 55 P.M. m.

The CAUSE OF DEATH* was as follows:

1 Coronary Thrombosis

(duration) ... yrs. ... mos. 13 ds.

CONTRIBUTORY (Secondary): Ter. Bronchopneumonia

(duration) ... yrs. ... mos. 7 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) J. S. Whitehead, M. D.

(Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery — Date of Burial: 4/25 1929

20 UNDERTAKER: Henry H. Mears & Son — ADDRESS: 805 N. Calvert

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45353

CERTIFICATE OF DEATH

1929 E 45353

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3207 Abell Avenue ST. 12-50 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alice Ellen Whittle

(a) RESIDENCE NO. 3207 Abell Avenue ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 81 yrs. 4 mos. 3 ds. How long in U. S., if foreign birth? - yrs. - mos. - ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward D. Whittle

6 DATE OF BIRTH (month, day, and year) Dec. 20, 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph P. McDonald

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Betz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Edward D. Whittle

(Address) 3207 Abell Avenue

15 Filed APR 24 1929 C. HANSON JONES, M. D., Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 19, 1929 to April 23, 1929

that I last saw her alive on April 23, 1929

and that death occurred, on the date stated above, at 8-8.30 P. m.

The CAUSE OF DEATH* was as follows:

Nephritis: chronic interstitial with renal suppression; Endocarditis, myocarditis, chronic; aricular fibrillation.

(duration) 3 yrs. mos. ds.

CONTRIBUTORY Rheumatism (arthritis, chronic), convalescent 4 years.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Henry Lyman Whittle, M. D.

19 (Address) 1229 Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem

DATE OF BURIAL 4/26 19 29

20 UNDERTAKER Henry U. Mears & Son

ADDRESS 805 N. Calvert

Spec.—2-29-28—L. F. S.—500 Bks.

E 45354 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 45354

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1220 Bank ST., 2-5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna Campbell

(a) RESIDENCE NO. 1220 Bank ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Michael Campbell

6 DATE OF BIRTH (month, day, and year) Dec 22/65

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	3	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER David Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Anna Campbell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Ezra Campbell

(Address) 1212 Bank St

15 Filed APR 24 1929 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 20 1929

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1929, to April 19, 1929

that I last saw h. alive on April 19, 1929

and that death occurred, on the date stated above, at 4:30 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jos L. Valentine M. D.

(Date) April 24/29 14 So Monroe

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ruxford Rd Ruby Cross — DATE OF BURIAL April 25/29

UNDERTAKER D. M. W. & Hepplen — ADDRESS 37 S Amer

Spec.—2-29-28—L. F. S.—500 Blks.

E 45355

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 45355

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 6507 Baltimore ave ST., (WARD) 16-37

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Mitchell

(a) RESIDENCE NO. 6507 Baltimore ave ST.; WARD

(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth

6 DATE OF BIRTH (month, day, and year) June 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	10	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown England

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Elizabeth Mitchell

(Address) 6507 Baltimore ave

15 Filed ..., 19... C. HAMPSON JONES, M.D. Registrar

Apr 26 1929 For. ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1929, to April 24, 1929, that I last saw him alive on April 23, 1929 and that death occurred, on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

CONTRIBUTORY (Secondary) None (duration) yrs. 6 mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Arthur Keirle, M. D.

Apr 24. 1929 (Address) Glendale, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel — DATE OF BURIAL April 26 1929

20 UNDERTAKER Wm Cole — ADDRESS 1217 St. Paul

Spec.—2-29-28—L. F. S.—500 Bks.

E 45356

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 45356

1—PLACE OF DEATH

REGISTERED NO. 5161

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2907 Windsor Ave ST., 5 WARD)

2—FULL NAME Shirley Cecil Belt

(a) RESIDENCE NO. 2907 Windsor ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lulu

6 DATE OF BIRTH (month, day, and year): Nov 6, 1851

7 AGE — Years: 77 | Months: 5 | Days: 17 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Freight Agt

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Baltimor & Ohio

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Osborn S Belt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mary Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Elizabeth S Belt
(Address) 2907 Windsor Ave

15 Filed 4 24 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 23-1929

17 I HEREBY CERTIFY, That I attended deceased from Jan. 29, 1929, to April 23 1929, that I last saw him alive on April 22 29 and that death occurred, on the date stated above, at 6.15 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. L. Cullen, M. D.

4/24/29 (Address) 2757 W. Mosher

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: 4 25 1929

20 UNDERTAKER: William Cook — ADDRESS: 1217 St Paul

Spec—12-23-21—E.B.R.S.—400 Bks.

E 45357

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45357

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 514 Richmond Ave St. Govans 10 27-48 Ward)

Registered No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Simon Rainaldi

(a) Residence No. 514 Richmond Ave St., ... Ward .....

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? 37 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Rainaldi

6-DATE OF BIRTH (month, day and year) Jul 29 1877

7-AGE. 52 yrs. 1 mos. 22 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Tailor

(b) General nature of industry, business, or establishment in which employed (or employer). Self

(c) Name of employer. Self

9-BIRTHPLACE (city or town) (State or Country). Italy

PARENTS.

10-NAME OF FATHER. Louis Rainaldi

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Italy

12-MAIDEN NAME OF MOTHER. Clara Rabone

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Italy

14-(Informant) Nida Rainaldi

(Address) 514 Richmond Ave

15-Filed APR 24 1929 C. HAMPSON JONES, M. D. Registrar. Per .....

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) April 22, 1929

17- I HEREBY CERTIFY, That I attended deceased from April 8 19 29 to April 22 19 29, that I last saw him alive on April 22 19 29, and that death occurred, on the date stated above, at 11 PM m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Cardiac Asthma

(Duration) ..... yrs. ..... mos. 14 ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Chas C Hampson M. D.

, 19 (Address) 4702 Park Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Gardens DATE OF BURIAL. 4 25 29

20-UNDERTAKER. Wm Cook ADDRESS 1217 E Fayette

Instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 45358

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11-001 E 45358

1-PLACE OF DEATH Franklin Square Hospital

CITY OF BALTIMORE: (No. Calhoun & Fayette St., 20-27 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nettie Canales

(a) RESIDENCE No. 2020 W Saratoga St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if of foreign birth? 36 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Oliver J Canales, Sr.

6 DATE OF BIRTH (month, day, and year) Aug. 27, 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	9	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Store keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mr. Edgar Connolly

(Address) 5842 Bloomis Ave

15 Filed APR 24 1929 C. HAMPSON JONES, M. D. Registrar

By ADK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24 1929

17

I HEREBY CERTIFY, That I attended deceased from April 22, 1929, to April 24, 1929, that I last saw h alive on April 24, 1929, and that death occurred, on the date stated above, at 11:08 A m.

The CAUSE OF DEATH was as follows:

Bronchopneumonia

following Influenza

(duration) 1 mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Elizabeth B. Sheldon M. D.

4/24 1929 (Address) Franklin Sq Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL 4/27 1929

20 UNDERTAKER J. H. Cook

ADDRESS 1217 E Lord St

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45359

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 45359

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 1612 N. Caroline ST. 9-17 WARD)

2—FULL NAME William C. Norris

(a) RESIDENCE NO. 1612 N. Caroline ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carolyn A. Norris

6 DATE OF BIRTH (month, day, and year) Oct. 20, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	6	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore City

PARENTS

10 NAME OF FATHER Clinton C. Norris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Virginia Frederick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Robert W. Norris

(Address) 3109 Hartford Rd.

15 Filed ..... 19 C. HAMPSON JONES, M.D.

241929 Per ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24, 1929

17 I HEREBY CERTIFY, That I attended deceased from August 1, 1927, to April 23, 1929, that I last saw him alive on April 23, 1929 and that death occurred, on the date stated above, at 8:50 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Myocarditis

CONTRIBUTORY (Secondary) Cerebral Hemorrhage (duration) 2 yrs. — mos. — ds.

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Edgar P. Sandrock, M. D.

, 19 (Address) Medical Arts Building

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem

DATE OF BURIAL 4 27 1929

20 UNDERTAKER W. M. Cook

ADDRESS 1217 E. Ford St

Spec.—1-10-21—M&T—1500 Bks.

E 45360 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100 E 45360

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 334 Canal ST. 11-7 (WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Chas. Sidney Rhoades

(a) RESIDENCE NO. 334 Canal ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced
~~HUSBAND of~~
~~(or) WIFE of~~ Rebecca Rhoades

6 DATE OF BIRTH (month, day, and year) — — 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Gardener
(b) General nature of industry, business, or establishment in which employed (or employer) 086
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Highlandtown Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) " Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) " Va

14 Informant Mary E. Rhoades
(Address) 334 Canal St.

15 Filed 4 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23. 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb 18 1929 to April 23. 1929, that I last saw him alive on April 23. 1929, and that death occurred, on the date stated above, at 5:30 P.m.

The CAUSE OF DEATH* was as follows:

Fat acute Nephritis

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? "

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) R. Lee Cole M. D.

4/23. 1929 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 4-25 1929

20 UNDERTAKER Daniel Carton

ADDRESS 916 Ca ave.

CAUTION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 45361

31 E 45361

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 861 Vine St. 18-26 Ward)

2-FULL NAME John Moody

(a) RESIDENCE NO. 861 Vine St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Negro	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Alice Moody

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day... hrs. or ... min.
	42			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Ohio
(c) Name of employer James Vance Const. Co

9 BIRTHPLACE (city or town)
(State or country) Basto. Md

PARENTS

10 NAME OF FATHER Douglas Moody

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Mrs Alice Moody
(Address) 861 Vine St

15 Filed ..... 19.. C. HAMPSON JONES, M. D. Registrar

10 24 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) ... yrs. 4 mos. ... ds.

CONTRIBUTORY (Secondary) Fractured Spine

(duration) 1 yrs. 2 mos. ... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Gellert M. D.

4-23. 1929 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary Cem

DATE OF BURIAL 4-25-29

20 UNDERTAKER David Cather & Co

ADDRESS 96

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45362

CERTIFICATE OF DEATH

159-003

E 45362

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. University Hosp St. 13-54 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Carnell Curvis

(a) RESIDENCE NO. 2606 (Usual place of abode) ST. Bruce Terrace WARD

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 9 1927

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	8	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work no

(b) General nature of industry, business, or establishment in which employed (or employer) no

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER William Curvis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mabel Whelan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs Curvis

(Address) 2606 Bruce Terrace

15 [illegible], 19[illegible] C. HAMPSON JONES [illegible]

Per [illegible]

R 24 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22, 1929

17 I HEREBY CERTIFY, That I attended deceased from February 28, 1929, to April 22, 1929, that I last saw him alive on April 22, 1929, and that death occurred, on the date stated above, at 11:10 A m.

The CAUSE OF DEATH* was as follows:

Cystic hygroma

over

(duration) yrs. 17 mos. ds.

CONTRIBUTORY (Secondary) Surgical Shock

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of April 22, 1929

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) L. L. Pumphrey, M. D.

4/22, 1929 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet

DATE OF BURIAL 4-26-29

20 UNDERTAKER D. Daniel Carlon

ADDRESS 916 Ca av

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45363

CERTIFICATE OF DEATH

1929

E 45363

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1636 Aisquith ST., 4446 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edward Joseph Hand.

(a) RESIDENCE NO. 1636 Aisquith ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary C. Hand.

6 DATE OF BIRTH (month, day, and year) Aug. 6. 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53	8	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman

(b) General nature of industry, business, or establishment in which employed (or employer) Bklds Aty

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER Edward Hand

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Ellen Ryan

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Frank A. Casey
(Address) 1636 Aisquith St

15 Filed ....., 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 21-1929.

17 I HEREBY CERTIFY, That I attended deceased from Oct. 21, 19 28, to April 21, 19 29
that I last saw h.. alive on April 21, 19 29
and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Hypertension
Arteriosclerosis
Chronic Interstitial Nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Myocard. Insuf.

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Hand

(Signed) Thos J. Turner, M. D.

4 W. 19 29 (Address) 2818 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem. DATE OF BURIAL 4/30/29

20 UNDERTAKER George J. Butts ADDRESS 1235 Hanford

4 24 1929

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45364

CERTIFICATE OF DEATH

31 E 45364

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 5407 Elsrode Ave ST. 27-47 (WARD)

2—FULL NAME Josephine B. Mack

(a) RESIDENCE NO. 5407 Elsrode Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 4 - 1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23	4	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baltimore Md

(b) General nature of industry, business, or establishment in which employed (or employer) Mutt Bro + Co

(c) Name of employer Dempsey

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Frederick Mack

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Barbara Mack

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Frederick Mack
(Address) 5407 Elsrode Ave

15 Filed ..... 19 HAMPSON JONES, M.D. Registrar

24 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/24/29

17 I HEREBY CERTIFY, That I attended deceased from Sept, 19 28, to 4/22, 19 29, that I last saw h alive on 4/22, 19 29 and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Hyla W Holley, M. D.

19 (Address) 5103 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL 4/25 1929

20 UNDERTAKER George F Ruth — ADDRESS 1735 Harford Ave

Spec.—2-29-28—L. F. S.—500 Bks.

E 45365

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

10-01 L

E 45365

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Sr. Balt Gen Hosp ST., 2353 WARD)

2—FULL NAME Edward Thatcher Sr.

(a) RESIDENCE NO. 7 West Houston (Ostend) ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elizabeth Thatcher

6 DATE OF BIRTH (month, day, and year): Aug 8 1870

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
58	8	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer): 015

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Phila Pa

PARENTS

10 NAME OF FATHER: Can't know

11 BIRTHPLACE OF FATHER (city or town) (State or country): "

12 MAIDEN NAME OF MOTHER: "

13 BIRTHPLACE OF MOTHER (city or town) (State or country): "

14 Informant: Edward Thatcher

(Address): 7 W. Houston St

15 Filed 24 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/23/29

17 I HEREBY CERTIFY, That I attended deceased from April 22, 1929, to April 23, 1929, that I last saw h. alive on April 23, 1929 and that death occurred, on the date stated above, at 6.45 P. m.

The CAUSE OF DEATH* was as follows:

Double Lobar Pneumonia.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Cardio Vascular Renal Disease

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) William H Tyson, M. D.

, 19 (Address) Sr Balt Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Leakin Hill Cem. — DATE OF BURIAL: April 25 1929

20 UNDERTAKER: H. Arnold Evans — ADDRESS: 1 E Preston

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45366

CERTIFICATE OF DEATH

161-002

E 45366

1—PLACE OF DEATH

REGISTERED NO. 13-57

CITY OF BALTIMORE: (No. 3511 Green Spring Ave ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lorraine Castagnera.

(a) RESIDENCE NO. 3511 Green Spring Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White.	Infant.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Infant.

6 DATE OF BIRTH (month, day, and year) April 23, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Martin Castagnera

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy.

12 MAIDEN NAME OF MOTHER Bertha Balliet.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Martin Castagnera.
(Address) 3511 Green Spring Ave.

15 Filed ....., 19.... C. HARRISON JONES, Registrar.

241928

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4.23.29

17 I HEREBY CERTIFY, That I attended deceased from 4.22.29, 19...., to 4.23., 19 29.

that I last saw h.er alive on 4.23.29, 19....

and that death occurred, on the date stated above, at 8-0. m.

The CAUSE OF DEATH* was as follows:

Dysteria in mother

(duration) ....yrs....mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs....mos....ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) (P Irving B. Tamben, M. D.

4.24.29, 19 (Address) 1432 William St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	April 25 1929

20 UNDERTAKER A. Leland Evans ADDRESS 35 E. Fort Ave

Spec.–7-17-26—A Co.—200 Bks.

E 45367

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

65-001

65 E 45367

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 415 Popular Grove St., 20-69 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Edward Ross Jr.

(a) RESIDENCE NO. 415 Popular Grove St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Nov. 4–1924.

7 AGE: Years 4 Months 5 Days ~~18~~

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particolar kind of work

(b) General natore of industry, bosiness, or establishment in which employed (or employer): None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER Charles E. Ross.

11 BIRTHPLACE OF FATHER (City or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER Dorothy Morgreth

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant Charles E. Ross.

(Address) 415 Popular Grove St.

15 Filed ..... 19 ..... C. HARRISON JONES, M. D. Registrar

24 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 22 19 29

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1929, to April 22, 1929, that I last saw h-im alive on April 22, 1929, and that death occorred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Splenomyelogenous Leukemia

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) E. L. Weaire, M. D.

, 19 (Address) 4000 Edmondson Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Good Shepherd Cemetery, Howard Co. Md. Date of Burial: April 25-1929.

20 UNDERTAKER: Charles J. Schwab. ADDRESS: 505 N. Monroe St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 45368 ✓ E 45368

57

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 122 S. Patterson Park Ave. ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Captain W. ASBURY MILLS

(a) RESIDENCE NO. 122 S. Patterson Park Ave. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Mills

6 DATE OF BIRTH (month, day, and year) April 12, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
69	68	8	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Policeman retired 2 years

(b) General nature of industry, business, or establishment in which employed (or employer) Patrolman 61

(c) Name of employer Baltimore Police Dept.

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Rev. Wrightson Mills

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Rebecca Dean

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. S. H. Knight (Daughter)

(Address) Frederick and Augusta Aves.

15 Filed 24 1929 C. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 19, 1929, to April 23, 1929, that I last saw h alive on April 23, 1929, and that death occurred, on the date stated above, at 5.50 p. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Oedema of Lungs

(duration) yrs. mos. ½ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sugar Tests & Urine

(Signed) A. A. Brudick, M. D.

, 19 (Address) 2221 E. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: Apr. 26 1929

20 UNDERTAKER: Henry Sander & Sons. Inc.

ADDRESS: BALTIMORE ST. & BROADWAY.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

45369

CERTIFICATE OF DEATH

179

E 45369

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Johns Hopkins Hospital St., 3-5 Ward)

2-FULL NAME Catherine Iavicoli

(a) RESIDENCE NO. 402 S. Eden St St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 10/21

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	7	9	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School Girl
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Michael Iavicoli

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Italy

12 MAIDEN NAME OF MOTHER Anna Mirc

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Italy

14 Informant Anna M. Iavicoli
(Address) 402 S. Eden St

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 24/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Burns of body & extremities
Clothing accidently caught fire
from gas heater while playing
at 412 S. Eden St.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. S. Gallen M. D.

4/24/29 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	Apr 29
20 UNDERTAKER	ADDRESS
Randall J Hoppel	300 E Eden

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is important. See instructions on back of certificate.

APR 25 1929

HAMSON JONES, Registrar

M. D.

Spec.—1-10-21—M&T—1500 Bks.

E 45370

HEALTH DEPARTMENT—CITY OF BALTIMORE

001

CERTIFICATE OF DEATH.

10 E 45370

1-PLACE OF DEATH Sinai Hospital

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST. 35 WARD)

2-FULL NAME Baby Theresa Tedeschi

(a) RESIDENCE NO. 1427 (Usual place of abode) Bank St. ST., ... WARD .....

Length of residence in city or town where death occurred 9 mos. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced. (write the word) Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) July 30 1927

7 AGE Years 1 Months 3. Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Victoria Tedeschi

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Emma Pappagallo

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Victoria Tedeschi (Address) 1427 Bank St

15 Filed ..... C. HAMPSON JONES, M. D. Registrar

R 251929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-24 1929

17 I HEREBY CERTIFY, That I attended deceased from 4-21, 1929, to 4-24, 1929,

that I last saw her alive on 4-24, 1929,

and that death occurred, on the date stated above, at 11 Y0 A m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Lobar)

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Empyema

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Bacteriological + Operation

(Signed) O. Hyman M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cem. | DATE OF BURIAL April 1929

20 UNDERTAKER Kendall & Hyppel | ADDRESS 320 Eden

CAUSE OF DEATH must be plainly stated. See instructions on back of certificates. TION is very important.

Spec.—1-10-21—M&T—1500 Bks.

E 45371 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 45371

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 23 S. Calhoun ST., 19 29 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie M. Musgrove

(a) RESIDENCE NO. 23 S. Calhoun ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (Write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Augustus M. Musgrove

6 DATE OF BIRTH (month, day, and year): March 14, 1844

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
85	1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: [illegible] Cobb

11 BIRTHPLACE OF FATHER (city or town) (State or country): —

12 MAIDEN NAME OF MOTHER: Sarah E. Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Mrs. Mary E. Ashburn

(Address) 23 S. Calhoun St.

15 Filed [illegible] 1929

WILLIAM C. HAMPSON JONES, M. D. Registrar

Per [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 22 1929

17 I HEREBY CERTIFY, That I attended deceased from April 20, 1929, to April 22, 1929, that I last saw her alive on April 22, 1929, and that death occurred, on the date stated above, at 9.30 P m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. O'Neill M. D.

4/24. 1929 (Address) 108 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: 4/25 1929

20 UNDERTAKER: Robert Brooks & Son

ADDRESS: Calhoun Hollins

CAUSE OF DEATH must be filled in plainly. See instructions on back of certificates. TION is very important.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45372

CERTIFICATE OF DEATH

E 45372

1—PLACE OF DEATH Latrobe Apt REGISTERED NO. 47

CITY OF BALTIMORE: (No. Charles & Read ST. 11-15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henrietta P. Ward

(a) RESIDENCE NO. Charles & Read ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (write the word)
Female	White	Widower

5a If ~~married~~, widowed, or ~~divorced~~ ~~HUSBAND of~~ (or) WIFE of Late

6 DATE OF BIRTH (month, day, and year) April 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	89			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Harlington Ward

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER ? Wilson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore Maryland

14 Informant Estie A Butler

(Address) Chapman Rd

15 Filed APR 25 1928 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25 1928.

17 I HEREBY CERTIFY, That I attended deceased from Dec. 1927, to April 1928, that I last saw h[illegible] alive on April 23 1928 and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma Metastasis & Brain

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Breast

Pulmonary (duration) 9 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 9 Jan 28

Was there an autopsy? No

What test confirmed diagnosis? Observation and Post Mortem

(Signed) Hilmer Hilmer Buckler M. D.

April 23 19 (Address) 806 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	April 25 1928
20 UNDERTAKER	ADDRESS
Henry Jenkins Son Co	Cathedral & Madison

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45373

E 45373

100-006

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1123 Lowe ST. 5-8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Thompson

(a) RESIDENCE NO. 1123 Lowe ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 24 1927

7 AGE	Years	Months	Days
	1	3	30

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Joseph Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Burke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mabel Thompson

(Address) 1123 Lowe St

15 Filed 1929 C. HAMPSON JONES, M. D.

R 25 1929 by Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23-29

17 I HEREBY CERTIFY, That I attended deceased from April 23 . 1929 to April 23 . 1929 that I last saw him alive on April 23 . 1929 and that death occurred, on the date stated above, at 7 p m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Physical

(Signed) Wm H Peck M. D.

4-24 1929 (Address) 508 Lemmon Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	Apr 25 1929

20 UNDERTAKER Lothe Gross ADDRESS 1405 McElderry St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45374 | 144

CERTIFICATE OF DEATH

E 45374

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 410 S. Eaton st ST. 26-37 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary B. Holston

(a) RESIDENCE NO. 410 S. Eaton st ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry R. Holston

6 DATE OF BIRTH (month, day, and year) Oct 25-1891

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
38	5	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kentucky

PARENTS

10 NAME OF FATHER James Brunner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kentucky

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Henry R. Holston
(Address) 410 S. Eaton st

15 C. HARRISON JONES, M. D.
Registrar

APR 25 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24-1929

17 I HEREBY CERTIFY, That I attended deceased from 4-24, 19 29, to 4-24, 19 29, that I last saw h alive on 4-24, 19 29, and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Cutaneous Emboli

1

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Placenta Previa

Post Partum Hemorrhage (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. Knight, M. D.

4-24, 19 29 (Address) 3326 Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cem — DATE OF BURIAL April 26, 29

20 UNDERTAKER Philip Herwig — ADDRESS 2016 Orleans st

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45375

CERTIFICATE OF DEATH.

124 E 45375

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4302 Wendover Rd. WARD) 27-49

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nan Houston

(a) RESIDENCE NO. 4302 Wendover Rd WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	b.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kent Co Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Mr Lawrence Soper

(Address) 4312 Wendover Road

Filed APR 25 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 17, 1929, to April 23, 1929.

that I last saw h-- alive on April 23, 1929

and that death occurred, on the date stated above, at 4 50 P m

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) High Blood Pressure (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) J. Hall, M. D.

, 19 (Address) 426 E 23 St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery — DATE OF BURIAL 4 28 1929

20 UNDERTAKER Mrs Chas L. Bailey — ADDRESS 1421 Jefferson St

TION is very important. See instructions on back of Certificate

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45376

CERTIFICATE OF DEATH.

90 E 45376

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1019 Valley ST. 10-14 WARD)

2-FULL NAME Jennie F. Callan

(a) RESIDENCE NO. 1019 Valley ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas J. Callan

6 DATE OF BIRTH (month, day, and year) June 18, 1863

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
65	10	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Mill Worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER James Bennett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ellen Burns

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Daughter Mrs Evans (Address) 1019 Valley

R 25 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23, 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 9 1928 to Apr 23 1929, that I last saw her alive on Apr 21 1929, and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) ? yrs. ? mos ds.

CONTRIBUTORY (Secondary) Asthma

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical sym

(Signed) L. M. C. Cohen, M. D.

4-25, 1929 (Address) 1104 Hartman

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	April 23, 1929

20 UNDERTAKER Elmer W. Conklin ADDRESS 924 E. Eager St

TION is very important. See instructions on back of certificate.

Spec.—1-12 23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45377 E 45377

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1219 Ensor ST. 10-14 WARD)

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert I. Buchanan

(a) RESIDENCE NO. 1219 Ensor ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 31, 1904

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
24	5	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schauffeur

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Wm J. Buchanan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary F. Murray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mother Married Buchanan (Address) 1219 Ensor St

15 H. HAMPSON JONES, M. D. Registrar

APR 25 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23 1927

17 I HEREBY CERTIFY, That I attended deceased from Dec 10th 1928 to April 23rd 1927, that I last saw him alive on April 18th 1927, and that death occurred, on the date stated above, at 6 p m.

The CAUSE OF DEATH* was as follows:

Pulm Tuberculosis

Coma Uraemia

(duration) hrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signature) Sadie Lowe, M. D.

19 (Address) 1 St. E Eager St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: April 28 1927

20 UNDERTAKER: Elmer W. Conklin — ADDRESS: 924 E Eager

TION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 45378

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 45378

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) In Garage loft Rear 849 Harlem Ave. (Ward) 1726

2-FULL NAME Robert Carter

(a) RESIDENCE NO. None St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
about 60			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Unknown
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Unknown
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant (Address) N. W. Police Informed

Filed APR 25 1929 H. C. HAMILTON JONES, M. D. Registrar

THE MORGUE

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22nd 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. Leslie Steele M. D.
Coroner

April 25 1929 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
UNIVERSITY OF MARYLAND	D. 19
20 UNDERTAKER Commissioner Health.	ADDRESS APR 25 1929

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

Levi J. Passey

45379

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

E 45379

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, No. 1307 Myrtle Ave ST. 7-24 WARD)

2-FULL NAME Levi J. Passey

(a) RESIDENCE No. 1307 Myrtle Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harriett

6 DATE OF BIRTH (month, day, and year) Dec. 25-1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	61	3	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Samuel Passey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Harriett Passey

(Address) 1307 Myrtle Ave

15 Filed APR 25 1929 C. HAMPSON JONES, M. D. Registrar

By RRM

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25 1929

17 I HEREBY CERTIFY, That I attended deceased from March 11, 1929, to April 25, 1929, that I last saw him alive on April 22, 1929 and that death occurred, on the date stated above, at 2 9 m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) 8 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. E. Passer, M. D.

, 19 (Address) 1307 Myrtle Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL 4/25/1929

UNDERTAKER Mrs. Geo. H. Holland ADDRESS 1631 Druid

TION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks. Lillian Sobus

E 45380

HEALTH DEPARTMENT—CITY OF BALTIMORE

31 E 45380

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST., 2-4 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lillian Sobus

(a) RESIDENCE NO. 1735 E. Lombard st. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1912

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	17			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Joseph Sobus

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Keeper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed 4-25, 1929 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 9, 1929, to April 24, 1929, that I last saw her alive on April 24, 1929, and that death occurred, on the date stated above, at 2:40 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical and X.

(Signed) Henry C. Smith, M. D.

4-24-1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stanislaus — DATE OF BURIAL April 27 1929

20 UNDERTAKER F. W. Ozazewski — ADDRESS 1930 Eastern Av

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45381

CERTIFICATE OF DEATH

9-002 E 45381

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1223 N. Calvert ST. 11-15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Augusta S. Vickery

(a) RESIDENCE NO. 1223 N. Calvert St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

a If married, widowed, or divorced HUSBAND of (or) WIFE of: Edward M. Vickery

6 DATE OF BIRTH (month, day, and year): May 1846

7 AGE: Years 82 Months 11 Days If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): NONE

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): England

PARENTS

10 NAME OF FATHER: Wm. Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Augusta Spratt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant: Mr. S. J. Vickery

(Address) 1223 N. Calvert St.

15 Filed 19 (Registrar)

R 25 1929 D. W. JONES REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 23, 1929

17 I HEREBY CERTIFY, That I attended deceased from , 1925, to 4-23, 1929, that I last saw HER alive on 4-22, 1929, and that death occurred, on the date stated above, at 7:00 A m.

The CAUSE OF DEATH* was as follows:

ARTERIOSCLEROSIS

HYPERTENSION

(duration) 6+ yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John E. Donaldson, M. D.

19 (Address) 1129 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem.

DATE OF BURIAL: April 25, 1929

20 UNDERTAKER: Wm. O. Mitchell Sons

ADDRESS 1900 Eutaw St.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45382

CERTIFICATE OF DEATH.

90 E 45382

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) 110 S. Fremont Road (Ward) 28-71

2-FULL NAME James. D. Kelly.

(a) RESIDENCE NO. 110 S. Fremont Road. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Widower.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary McNulty Kelly

6 DATE OF BIRTH (month, day, and year): May 22nd 1841

7 AGE: Years 87 | Months 11 | Days 0 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Balto.

(State or country): Md.

PARENTS

10 NAME OF FATHER: James. Kelly

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Ireland.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Ireland.

14 Informant: Lawrence L. Kelly.

(Address): 110 S. Fremont Road.

15 Filed 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 22 1929

17

I HEREBY CERTIFY, That I attended deceased from Oct 1, 19 24, to Apl. 22, 19 29.

that I last saw him alive on Apl 21, 19 29,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary): Old age.

(duration) 1 yrs. mos. ds.

18 Where was disease contracted? Unknown.

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Wright & Blake M. D.

19 (Address) 719 Mud. Arc. Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery Date of Burial Apr. 26 29

20 UNDERTAKER: Margaret J. Flynn ADDRESS 1422 Eutaw St.

OF DEATH in plain terms, so that it may be properly classified. Every item is very important. See instructions on back of certificates.

R 25 1929

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45383

CERTIFICATE OF DEATH

129 ✓

REGISTERED NO. E 45383

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 710 Linnard St ST. 16-67 WARD)

2—FULL NAME Chauncey M. Darby

(a) RESIDENCE NO. 710 Linnard St ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Addie Darby

6 DATE OF BIRTH (month, day, and year): Oct 28, 1850

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
78	5	27	26

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Groceman retired

(b) General nature of industry, business, or establishment in which employed (or employer): 034

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): New York

PARENTS

10 NAME OF FATHER: Joseph Darby

11 BIRTHPLACE OF FATHER (city or town) (State or country): New York

12 MAIDEN NAME OF MOTHER: Lydia Chesbrough

13 BIRTHPLACE OF MOTHER (city or town) (State or country): New York

14 Informant: Mrs Addie Darby

(Address): 710 Linnard St

15 Filed APR 25 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 24. 1929.

17 I HEREBY CERTIFY, That I attended deceased from ..., 1926, to April 24, 1929, that I last saw h in alive on April 24, 1929 and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis - arterio sclerosis
Chronic Endocarditis - hypertension
Hypertrophied Prostate

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary): Uraemia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Sh Weisig Jr, M. D.

4/25, 1929 (Address) 4000 Edmonson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery.	Apr 27, 1929.
20 UNDERTAKER: John F. Cowan & Son	ADDRESS: 901 Hollins St.

Spec.—1-12-23—M&T—500 Bks.

E 45384

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45384

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St. Agnes Hospital. REGISTERED NO. 1014

CITY OF BALTIMORE: (No. Wilkins & Caton Ave ST. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME J. Edwin Lawler.

(a) RESIDENCE No. 1514 Mt. Royal Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. 10 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 16th 1882

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	46	10	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work [redacted] Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Andrew J. Lawler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Lilly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Mary E. Lawler (Mother)

(Address) 1514 Mt. Royal Ave.

APR 25 1929 HARRISON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 24 1929

17 I HEREBY CERTIFY, That I attended deceased from Apr, 16, 1929, to Apr, 24, 1929, that I last saw him alive on Apr, 24, 1929, and that death occurred, on the date stated above, at 100 P m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Myocarditis, Endocarditis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam. + History

(Signed) R M Cresson, M.D.

. 19 (Address) St Agnes Hosp Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL April 26 1929

UNDERTAKER Lilly & Gaia

ADDRESS 1020 Wyoming

ATTENTION is very important. See instructions on back of certificate

Spec.—2-29-28—L. F. S.—500 Blks.

E 45385

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-601 E 45385

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. St. Josephs Hosp ST., 1-3 WARD)

2—FULL NAME Elizabeth Gehrmann

(a) RESIDENCE NO. 520 South Luzerne Ave ST., 1 WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 7 mos. 2 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Late Wm Gehrmann

6 DATE OF BIRTH (month, day, and year) Sept. 20th 1860

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
68	7	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Keeper

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER John Heinrich

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Anna Kaad

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant William Gehrmann
(Address) 522 Luzerne Ave.

15 Filed ..... 19 C. HAMPSON JONES, M. D.
Registrar

R 25 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22-1929

17

I HEREBY CERTIFY, That I attended deceased from Apr. 16, 1929, to Apr. 22, 1929, that I last saw her alive on Apr. 22, 1929 and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Hypertension

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage (duration) ..... yrs. ..... mos. 6 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) N. Mc Ilvaine, M. D.

4-22, 1929 (Address) St Josephs Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cemetery	April 26th 1929
20 UNDERTAKER Ray Miller Inc.	ADDRESS 10 W. Hoffman St

Spec.—1-12-23—M&T—500 Bks.

Truxon

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45386 CERTIFICATE OF DEATH. X 124 E 45386

1-PLACE OF DEATH Provident Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. Division ST., 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stephen Trenor

(a) RESIDENCE NO. 906 Edmondson Ave Catonsville WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emma Truxon

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 65; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland Baltimore

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Mrs. H. Durall 906 Edmondson Ave Catonsville Md

15 Filed: 4/25 1929 C. HAMILTON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 22 1929

17 I HEREBY CERTIFY, That I attended deceased from Apr 21, 1929, to Apr 22, 1929, that I last saw him alive on Apr 22, 1929, and that death occurred, on the date stated above, at 8:15 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

with

Uremia

(duration) undetermined hrs. ds.

CONTRIBUTORY (Secondary): Hypertension

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Urine & Blood.

(Signed) W. B. Butler M. D.

1929 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mountcastle — DATE OF BURIAL: 4/25 1929

20 UNDERTAKER: Samuel D Hemsley — ADDRESS: 578 Biddle

TION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45387

CERTIFICATE OF DEATH

+101-802 E 45387

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital ST. 9-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Brooks

(a) RESIDENCE NO. Pikesville, Md ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 15 1913

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	15	5	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Co. (State or country) Maryland

PARENTS

10 NAME OF FATHER John C. Brooks

11 BIRTHPLACE OF FATHER (city or town) Balto. Co. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ella Ruby

13 BIRTHPLACE OF MOTHER (city or town) Balto. Co. (State or country) Maryland

14 Informant Ella Brooks (Address) Stemmers Run Md.

15 Filed G. HAMPSON JONES, M. D. Registrar

251929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/23/29

17 I HEREBY CERTIFY, That I attended deceased from 4/5/29, 19..., to 4/23/29, 19..., that I last saw him alive on 4/22/29, 19..., and that death occurred, on the date stated above, at 4:18 P. m.

The CAUSE OF DEATH* was as follows:

lung abscess

(duration) yrs. mos. 18 ds.

CONTRIBUTORY (Secondary) cardiac decompensation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 4/6/29

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. E. Zimmerman, M. D.

, 19 (Address) St Joseph's Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's Cemetery	April 26 1929

20 UNDERTAKER Frederick Lassahn ADDRESS Long Fullerton

Spec.—2-29-28—L. F. S.—500 Bks.

E 45388

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1928 26 / 31 E 45388

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 6306 Everall Ave. ST. Parkside WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William O. Kluge

(a) RESIDENCE NO. 6306 Everall Ave. ST. Parkside WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Kluge

6 DATE OF BIRTH (month, day, and year) June 26th 1902

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
26	9	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Hochschild & Kohn Balto.

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Charles F. Kluge

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Anna M. Klenner

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Anna M. Kluge
(Address) 6306 Everall Ave.

15 APR 25 1929 C. HAMPSON JONES, M. D., 19
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24 29

17 I HEREBY CERTIFY, That I attended deceased from Jan, 19 28, to April 23, 19 29, that I last saw him alive on April 23, 19 29 and that death occurred, on the date stated above, at 2.40 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Albert E. Webster, M. D.

4/25, 19 29 (Address) 6409 Belair Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	April 27, 1929
20 UNDERTAKER	ADDRESS
Frederick Lassahn Son	Fullerton

Spec.—1-12-23—M&T—500 Blks.

E 45389

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74 E 45389

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3013 Christopher Ave ST. 27-43 WARD

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert A. Dougherty

(a) RESIDENCE NO. 3013 Christopher Ave ST. WARD
(Usual place of abode)
Length of residence in city or town where death occurred Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Jennie Dougherty

6 DATE OF BIRTH (month, day, and year) May 30 - 1859

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
69	10	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Bank Watchman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John J.C. Dougherty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Mary E. Stapleton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs Jennie Dougherty
(Address) 3013 Christopher Ave

15 Filed APR 25 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24 1929

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1929, to April 24 1929, that I last saw h[illegible] alive on April 23, 1929 and that death occurred, on the date stated above, at 2 p m

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F H Gunkans, M. D.
(Address) 1400 Hanford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery — DATE OF BURIAL 4/26 1929

20 UNDERTAKER Chas S. Grace & Son — ADDRESS 1180 W. Mt Royal

TION is very important See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45390

HEALTH DEPARTMENT—CITY OF BALTIMORE

129

E 45390

CERTIFICATE OF DEATH

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

CITY OF BALTIMORE: (No. [redacted] 3-5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie Williams

(a) RESIDENCE NO. 1104 Duke Alley ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced (or) WIFE of Edward Williams

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records of

(Address)

15 Filed [illegible] Registrar. C. HAMPSON JONES M. D.

APR 25 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 22, 1929

17

I HEREBY CERTIFY, That I attended deceased from April 5, 1929, to April 22, 1929,

that I last saw h[illegible] alive on April 22, 1929

and that death occurred, on the date stated above, at 1:05 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial nephritis
Acquired Hemorrhoids, mitral, with
Compensation Disturbance, with
Acute exacerbation (duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Hypertension, arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) Marion A. Wyeth M. D.

, 1929 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL APR 25 1929

20 UNDERTAKER

ADDRESS

Cor.—10-10-29—A Co.—100 Blks.

E 45391

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45391

CERTIFICATE OF DEATH

x 86

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Johns Hopkins Hospital St., 7-9 Ward)

2-FULL NAME Charles Francis Dale Hodgkinson

(a) RESIDENCE NO. Piney Pt., St. Mary's Co., Md St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. / ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 19/1915

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	13	8	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Piney Pt., Md.

PARENTS

10 NAME OF FATHER Thos. A. E. Hodgkinson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) S.C.

12 MAIDEN NAME OF MOTHER Olive G.G.Guyther

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto., Md.

14 Informant Father
(Address) Piney Pt., Md.

15 Filed 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 25/29

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumococcus Meningitis
Perforative Otitis Media

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? At hopkins Hospital

What test confirmed diagnosis?

(Signed) [illegible] M. D.

4/25/29 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Valley Lee Charles Co Md

DATE OF BURIAL 4/28 1929

20 UNDERTAKER Gu Weber & Son 2508 Edmondson Ave

ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45392 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH E 45392

1—PLACE OF DEATH Johns Hopkins Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John W. Johnson

(a) RESIDENCE NO. Altha Florida ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W.	S.

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Florida

PARENTS

10 NAME OF FATHER J. H. Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Fla

12 MAIDEN NAME OF MOTHER Lola Bell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Fla

14 Informant Records
(Address) Johns Hopkins Hospital

15 Filed 1929 H. JAMPSON JONES, M. D. H. JAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25-1929

17 I HEREBY CERTIFY, That I attended deceased from April 23, 1929, to April 25, 1929, that I last saw him alive on April 25, 1929 and that death occurred, on the date stated above, at 4:08 A m.

The CAUSE OF DEATH* was as follows:

Tumor of Brain Tissue, malignant

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exploratory Operation 4-23-29

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 4-23-29

Was there an autopsy? Yes

What test confirmed diagnosis? Operation + Autopsy

(Signed) I. R. Trimble, M. D.

April 25 1929 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL altha Fla — DATE OF BURIAL 4/25/29

20 UNDERTAKER Joseph Ahrens — ADDRESS 221 Bway

Spec.—2-29-28—L. F. S.—500 Bks.

Dr Scott, 2435 Md Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45393

CERTIFICATE OF DEATH

E 45393

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 2315 N. Charles ST. 12-56 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Martha B. Whiteford

(a) RESIDENCE NO. 2315 N. Charles ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 6, 1852

7 AGE: Years 77 | Months | Days 18 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Whiteford Md.

PARENTS

10 NAME OF FATHER: Eldridge Whiteford

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Elizabeth Silver

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Susan C. Jones

(Address) 2315 N. Charles St

15 Filed APR 25 1929 19

C. HAMPSON JONES, M.D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 24, 1929

17 I HEREBY CERTIFY, That I attended deceased from ..., 19 20, to April 24, 19 29

that I last saw her alive on April 24, 19 29

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Cardio Vascular Hypertension

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical examination

(Signed) Roger M. Scott, M. D.

4/25, 19 29 (Address) 2435 Maryland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Stateville Presbyterian

DATE OF BURIAL: 4 27 19 29

20 UNDERTAKER: [illegible] Cook

ADDRESS: 217 St Paul St

Spec. -7-1... A Co.—200 Bks.

E 45394

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45394

CERTIFICATE OF DEATH

1-PLACE OF DEATH Maryland General Hosp. REGISTERED NO.

City of BALTIMORE: (No. Howard & Madison St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William S. Heath

(a) RESIDENCE NO. 424 Buford Rd. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna

6 DATE OF BIRTH (month, day, and year): Nov 9-1876

7 AGE 52 Years Months 5 Days 15 IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Painter 050

(b) General nature of industry, business, or establishment in which employed (or employer): Balto City

(c) Name of employer

9 BIRTHPLACE (city or town): Balto Md

(State or country)

PARENTS

10 NAME OF FATHER: Alfred Heath

11 BIRTHPLACE OF FATHER (City or town): England

(State or country)

12 MAIDEN NAME OF MOTHER: Alice Morfort

13 BIRTHPLACE OF MOTHER (city or town): Columbus

(State or country): Ohio

14 Informant: Hosp Records

(Address)

15 C. HAMPSON JONES, M. D.

Per

Registrar

R 25 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 24 1929

17 I HEREBY CERTIFY, That I attended deceased from April 21, 1929, to April 24, 1929, that I last saw h. in alive on April 24, 1929, and that death occurred, on the date stated above, at 5 30 P. m.

The CAUSE OF DEATH* was as follows:

Acute appendicitis

Intestinal Obstruction.

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary): Lobar pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of April 23

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. L. Reifschneider M. D.

4/24 1929 (Address) Md General Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery — Date of Burial 4/27 1929

20 UNDERTAKER: William Cook — ADDRESS 1214 Pat Rd

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Dr. Hall, Rustletown Rd

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45395

CERTIFICATE OF DEATH

1929

E 45395

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2927 N. North Ave ST. 15-67 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John F Cummings

(a) RESIDENCE NO. 2927 N. North Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Nov 30, 1853

7 AGE — Years: 75 | Months: 11 | Days: 24 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Talbot Co Md

PARENTS

10 NAME OF FATHER: William A Cummings

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Rebecca Kersey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Martha Gibson

(Address) 2927 N. North Ave

15 MAR 25 1929, 19 C. HAMPSON JONES, M. D. Registrar

By CRW

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 24, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1924, to April 24, 1929, that I last saw h alive on April 24, 1929 and that death occurred, on the date stated above, at 5.30 P m.

The CAUSE OF DEATH* was as follows:

Hemiplegia

(Cerebral hemorrhage)

(duration) 4 yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Nephritis. (Parenchymatous) (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Physical.

(Signed) Milton P. Hall M. D.

, 19 (Address) Wylie av - Rustletown Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet, St Michaels

DATE OF BURIAL: 4 27 1929

20 UNDERTAKER: D. W. Cook

ADDRESS: 217 E Fayette St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45396

CERTIFICATE OF DEATH

E 45396

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1203 Cathedral St., (WARD) 24

2—FULL NAME Virginia Woodland.

(a) RESIDENCE NO. 1203 Cathedral ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widow James Woodlin

6 DATE OF BIRTH (month, day, and year) March 1st 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	1	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) Self.

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Samuel Dunn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Elizabeth McIntyre

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Anna Cowell

(Address) 1203 Cathedral St

Filed APR 25 1929 19 C. HAMPSON JONES, M. D. Registrar

By BRW

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24/29

17 I HEREBY CERTIFY, That I attended deceased from March 23, 1929, to April 24, 1929, that I last saw her alive on April 24, 1929 and that death occurred, on the date stated above, at 10 30 P m.

The CAUSE OF DEATH* was as follows:

Valvular heart disease & myocardial degeneration of the heart

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) 1 yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A. C. Bacon, M. D.

4/24 1929 (Address) 3907 Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Richmond Va

DATE OF BURIAL April 26 1929

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

Spec.–7-17-26—A Co.—200 Bks.

E 45397

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45397

CERTIFICATE OF DEATH

129

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 1504 Mosher St S. 16-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Jones

(a) RESIDENCE NO. 428 Carrollton ave St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: colored

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Eska Jones

6 DATE OF BIRTH (month, day, and year): 3-1-1876

7 AGE Years: 52 (53) Months: — Days: —

IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Longshoreman

(b) General nature of industry, business, or establishment in which employed (or employer): B & O R R (07)

(c) Name of employer

9 BIRTHPLACE (city or town): Snow Hill Md

(State or country)

PARENTS

10 NAME OF FATHER: Samuel Jones

11 BIRTHPLACE OF FATHER (City or town): Snow Hill Md

(State or country)

12 MAIDEN NAME OF MOTHER: Julia ?

13 BIRTHPLACE OF MOTHER (City or town): Snow Hill Md

(State or country)

14 Informant: Milton Johnson

(Address) 113 W. Henrietta St

15 Filed: APR 25 1929 C. HAMPSON JONES, M. D. Registrar

Per RRH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-25-1929

17 I HEREBY CERTIFY, That I attended deceased from 4-7, 1929, to 4-25, 1929, that I last saw him alive on 4-25, 1929, and that death occurred, on the date stated above, at 6.30 A.M.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary): Nephritis

unknown (duration) — yrs. — mos. — ds.

18 Where was disease contracted

If not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Laboratory Examination

(Signed) Samuel Saunders, M. D.

4-25, 1929 (Address) 1024 N. Stricker St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

Date of Burial: 4-26 1929

20 UNDERTAKER: Daniel Easton

ADDRESS 916

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCU[illegible]ION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 45398

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45398

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 11 W. Preston St. 11-24 Ward)

2-FULL NAME Kate Ellen E. Patterson

(a) RESIDENCE NO. 11 W. Preston St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced. (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Andrew Patterson

6 DATE OF BIRTH (month, day, and year): 12-2-1860.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	68	4	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Proprietor of Rooming House

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town): Southampton

(State or country): England

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town):

(State or country): England

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): England.

14 Informant: Andrew Patterson

(Address): Texarkana Texas.

15 Filed 4-27-29 C. HAMPSON JONES, M. D. Registrar

Pmt RRH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 23 1929

17

I HEREBY CERTIFY, That I attended deceased from April 19- 1929, to April 23- 1929, that I last saw her alive on April 22- 1929; and that death occurred, on the date stated above, at 3:50 P. m.

The CAUSE OF DEATH* was as follows:

Dilatation of Heart

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary): none

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Chester Riland, M. D.

4-23- 1929 (Address) 253 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem

Date of Burial: 4-26 1929

20 UNDERTAKER: Daniel Easton

ADDRESS 916 Dr. ave

OF DEATH in plain terms, so that it may be properly classified. Fill Schedule of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

E 45399 HEALTH DEPARTMENT—CITY OF BALTIMORE E 45399

CERTIFICATE OF DEATH.

REGISTERED NO. C 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 871 Hollins st S 18-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nellie Lapointe

(Residence in Baltimore: No. 871 Hollins st, Baltimore City St.; yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Femal Col

4-COLOR OR RACE,

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word.) Widow

6-DATE OF BIRTH, ..., 1865
(Month) (Day) (Year)

7-AGE, 64 yrs. mos. ds.

If LESS than 1 day, hrs. or min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) 870

9-BIRTHPLACE, (State or Country), N. C.

PARENTS.

10-NAME OF FATHER, Dont know

11-BIRTHPLACE OF FATHER (State or Country), N. C.

12-MAIDEN NAME OF MOTHER Emma Lee

13-BIRTHPLACE OF MOTHER (State or Country), N C.

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mat Rodgers

(Address) 871 Hollins St

15- Filed ....., 1929 C. HAMPSON JONES, M. D. Registrar.

Per .....

R 25 1929

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, April 23, 1929
(Month) (Day) (Year)

17- I HEREBY CERTIFY, That I attended deceased from Febry 1 1929, to April 23 1929, that I saw h 3 3a alive on April 23 1929, and that death occurred, on the date stated above, at 4 30 p m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(Duration) yrs. 2 mos. 3 ds.

CONTRIBUTORY (Secondary) Nephritis chron

(Duration) yrs. mos. 3 ds.

(Signed) Thomas H Brown M. D.

April 28 1929 (Address) 1 W Mulberry

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Mt Auburn Cem

DATE OF BURIAL, April 26, 1929

20-UNDERTAKER Hunt Custer

ADDRESS 916 Lemmon

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45400

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45400

CERTIFICATE OF DEATH

129

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 19-26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lucy Bullock

(a) RESIDENCE NO. 1629 W. Lexington ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Andrew Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Virginia McDowell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Records of

(Address): Baltimore City Hosp.

15 Filed 4-29-1929, 16 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 23, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 12, 1929 to April 23, 1929.

that I last saw her alive on April 23, 1929

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH was as follows:

Chronic interstitial nephritis with edema

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary) Fibrosis Pericarditis, Hydrothorax, Hypertension

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) Harvey W. Ft[illegible] M. D.

, 19 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	4-26 1929
20 UNDERTAKER David Carter	ADDRESS 916 Ca ne

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45401

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45401

CERTIFICATE OF DEATH

129

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 713 S Monroe St. WARD 3)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Apolonia Buczkowska

(a) RESIDENCE NO. 713 S Monroe St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if foreign birth 56 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wallison

6 DATE OF BIRTH (month, day, and year) Jan 9 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	3	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Teresa Piechocki

(Address) 713 S Monroe St

15 Filed APR 25 1929 19 C. HAMPSON JONES, M. D.

By Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan. 17, 1929 to April 25, 1929

that I last saw her alive on April 25, 1929

and that death occurred, on the date stated above, at 2:20 A.m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

Mitral Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Alexander Duncan Ward, M. D.

19 (Address) 7359 Eastern Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cem	April 27 1929
20 UNDERTAKER	ADDRESS
Jn. W. E. Deppe Sons	322 Conn Av

important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45402

CERTIFICATE OF DEATH.

1884 E 45402

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (N... Ward

2-FULL NAME Russell W Klausmeyer

(a) RESIDENCE NO. 3302 E Hamilton st. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. 6 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 3 1923 4/4/23

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	5	6	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto Md

PARENTS

10 NAME OF FATHER S. M Klausmeyer

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto

12 MAIDEN NAME OF MOTHER Mrs Ida D Dentler

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto

14 Informant S. M Klausmeyer

(Address) 3302 E Hamilton Ave

Filed APR 25 1929 C. HAMPSON JONES, M. D., Registrar

By ADR

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/24 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

thereon and from the evidence obtained by said Inquest

find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Injuries from Auto Accident

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.
(Coroner)

4/25, 1929 (Address) 3632 Roland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs. ..... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Date of Burial 11/27 1929

20 UNDERTAKER Martin W. Dippel ADDRESS 112 N Arnold st

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45403

CERTIFICATE OF DEATH.

E 45403

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hosp. (St.) 20-27 (Ward)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nellie F. Colton

(a) RESIDENCE NO. 1802 W. Lexington ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. . mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	W.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 10-7-1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	5	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Wellington Colton

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Augusta Harper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant (Address) J. Wellington Colton 1802 W. Lexington St

15 Filed APR 25 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/25 1929

17 I HEREBY CERTIFY, That I attended deceased from 4/21, 1927, to 4/25, 1927, that I last saw her alive on 4/25, 1929, and that death occurred, on the date stated above, at 3:45 A. m.

The CAUSE OF DEATH* was as follows:

Bilateral Lobar Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Typical consolidation

(Signed) A. A. Silver, M. D.
, 19 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — DATE OF BURIAL 28 Apr 29

20 UNDERTAKER Portiss & Poe — ADDRESS 1723 W. Lafayette Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Every question must be answered. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 45404

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 125 E 45404

1-PLACE OF DEATH Maryland General Hosp. REGISTERED NO.

City of BALTIMORE: (No. Howard & Madison St. 11-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cora E Benson

(a) RESIDENCE NO. Westminster Md St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ernest L. Benson

6 DATE OF BIRTH (month, day, and year): Oct 26, 1883

7 AGE: Years 45 Months 5 Days 29 IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None. 07

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Reisterstown Md

PARENTS

10 NAME OF FATHER: Judson Matthews

11 BIRTHPLACE OF FATHER (City or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Cole

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Hosp Record

(Address)

APR 26 1929

H. HAMPSON JONES, M. D. Registrar

Per RHC

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 25 1929

17 I HEREBY CERTIFY, That I attended deceased from April 24 1929 to April 25 1929 that I last saw h[illegible] alive on April 25 1929 and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows: Acute Hemorrhagic Pancreatitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Acute Hemorrhagic Pancreatitis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of April 25

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) [illegible] M. D.

4/25 1929 (Address) Md Gen-Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cem. Date of Burial 4-30 1929

20 UNDERTAKER: H Bankard & Son ADDRESS Westminster Md

This Should Be Carefully Examined, So That it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 7-17-26 A Co. 200 Bks.

Barrett

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 45405 — 57 — E 45405

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1024 Druid Hill St., (Ward) 17-24

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Barrett

(a) RESIDENCE NO. 1024 Druid Hill St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Samuel Barrett

6 DATE OF BIRTH (month, day, and year): 1878

7 AGE — Years: 51 — Months: — — Days: — — IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Washington

(State or country) D C

PARENTS

10 NAME OF FATHER Gaswray

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Washington D C

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Samuel Barrett

(Address) 1024 Druid Hill Ave

C. HAMPSON JONES, M. D.

Registrar

R 281929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

April 24 1929

17 I HEREBY CERTIFY, That I attended deceased from April 1 1929 to April 24 1929

that I last saw h[illegible] alive on April 24 1929

and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 1 yrs. mos. ds.

CONTRIBUTORY Hypertension

(Secondary)

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) Chas P Clemens, M. D.

Apr 27, 1929 (Address) 1 E Mt Vernon Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — Date of Burial: Apr 27 1929

20 UNDERTAKER: John H. Toadvine — ADDRESS 1027 Druid Hill

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—800 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45406

CERTIFICATE OF DEATH

74001

REGISTERED NO. E 45406

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 810 Edmondson St., 14-16 WARD)

2—FULL NAME Annie Bowans

(a) RESIDENCE NO. 810 Edmondson ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colrd	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible] 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER [illegible] Geo Bagwell

11 BIRTHPLACE OF FATHER (city or town) (State or country) [illegible] Va

12 MAIDEN NAME OF MOTHER Mary Rozell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mary C. Bowans

(Address) 810 Edmondson

15 Filed ... 19... Registrar

261929 C. HAMPSON JONES, M. D.

Per [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 23 1929

17 I HEREBY CERTIFY, That I attended deceased from Apr. 20, 1929, to Apr. 23, 1929, that I last saw her alive on Apr 23, 1929 and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

... (duration) ... yrs. 4 mos. ... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) David Evans M.D. M. D.

Apr 24, 1929 (Address) 1116 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	Apr 26, 1929
20 UNDERTAKER John H. Frazier	ADDRESS 1027 Hanover

Cor.—12-9-25—A Co.—200 Bks.

E 45407

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45407

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Union Memorial Hospital St. Ward)

2-FULL NAME Sadie M. Miller

(a) RESIDENCE NO. 327-E-30 St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: R. Walter Miller

6 DATE OF BIRTH (month, day, and year): Jan 31-1891

7 AGE: Years 38 Months 2 Days 24 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Balto

(State or country): Md

PARENTS

10 NAME OF FATHER: Wm A Getz

11 BIRTHPLACE OF FATHER (city or town): Md

(State or country)

12 MAIDEN NAME OF MOTHER: Sarah Eleaver

13 BIRTHPLACE OF MOTHER (city or town): Md

(State or country)

14 Informant: R. Walter Miller

(Address): 327-E. 30 St

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-25 1929

17 I HEREBY CERTIFY That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Injuries from Accidental

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) John J. Morrison M. D. (Coroner)

4/25 1929 (Address) 2632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loraine Park Cemetery Date of Burial: April 27 1929

20 UNDERTAKER: John B. Spence ADDRESS: 1325 N Caroline St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PR 26 1929

C. HAMPSON JONES, M. D.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45408

CERTIFICATE OF DEATH

74-001

E 45408

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Pronounced dead at

City of Baltimore: (No. St. Joseph Hospital St., 8-1 Ward)

2-FULL NAME Mary J. Rexroath

(a) RESIDENCE NO. 2005 Ellsworth St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F	W	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Henry Rexroath

6 DATE OF BIRTH (month, day, and year) July 15/1862

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	66	9	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER Henry Bickel

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary -------

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Catherine E. Mohr
(Address) 2005 Ellsworth St

Filed APR 26 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 23/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:
Probably Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Bacon M. D.

4/25/29 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL 4/26/1929

20 UNDERTAKER George J. Ruth — ADDRESS 1335 Harford Ave

Filed APR 26 1929 C. HAMPSON JONES, M. D. Registrar

Per 10792

IMPORTANT—Undertaker is required to secure a Burial Permit before interment, cremation or removal of body. Physician is required to fill out CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45409

HEALTH DEPARTMENT—CITY OF BALTIMORE

31 E 45409

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3419 Dupont Ave (St.) 27-16 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Daisy H. Poisal.

(a) RESIDENCE NO. 3419 Dupont Ave St. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 ~~Single, Married~~, Widowed, or Divorced, (write the word): Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: John M. Poisal

6 DATE OF BIRTH (month, day, and year): March 5 1877

7 AGE: Years 52 | Months 1 | Days 8 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: John R. Poisal

(Address) 3419 Dupont Ave

15 Filed ... 19 ... C. HAMPSON JONES, M. D. Registrar

261929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 23/29.

17 I HEREBY CERTIFY, That I attended deceased from Aug, 1928, to April 23, 1929, that I last saw ~~him~~ her alive on April 23, 1929 and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of no

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Evan J Kelly, M. D.

4/25/29 (Address) 608 Dumbarton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — DATE OF BURIAL: April 26 1929

20 UNDERTAKER: Elmwood Elson — ADDRESS: 365 Eastern Ave

Spec.—2-29-28—L. F. S.—500 Blks.

E 45410

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45410

99-001

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 21-55

CITY OF BALTIMORE: (No. 7105 Park Heights Ave ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John R. Sherwood

(a) RESIDENCE NO. 7105 Park Heights Ave. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Isabella Miller

6 DATE OF BIRTH (month, day, and year) July 16, 1843

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	85	9	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER --- Sherwood

11 BIRTHPLACE OF FATHER (city or town) ----
(State or country)

12 MAIDEN NAME OF MOTHER Rebecca Fox

13 BIRTHPLACE OF MOTHER (city or town) ---
(State or country) ---

14

Informant Watson E. Sherwood

(Address) 2818 St. Paul St.

APR 26 1929 C. HAMPSON JONES, M. D.

Filed Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24 1929

17

I HEREBY CERTIFY, That I attended deceased from April 7, 1929, to Apr 24, 1929, that I last saw him alive on April 24, 1929 and that death occurred, on the date stated above, at 8. 0c P m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

(duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary) Senile debility

(duration) [illegible]

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Auscultation & percussion

(Signed) W. O. Mitchell, M. D.

, 19 (Address) Residence

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	Apr. 28, 19 29

20 UNDERTAKER John O. Mitchell & Sons, M. D. Mitchell

ADDRESS 1900 Eutaw Pl.

Important. See instructions on back of certificate.

Special 12-9-25 — 500 Bks.

E 45411

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45411

CERTIFICATE OF DEATH.

137

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Church Home + Inf. St. 70-22 Ward)

2-FULL NAME Miss Anna Stumpner

(a) RESIDENCE NO. 1916 W. Saratoga St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 20/1861

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	68	3	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home duties

(b) General nature of industry, business, or establishment in which employed (or employer) Own

(c) Name of employer

9 BIRTHPLACE (city or town) Md.

(State or country)

PARENTS

10 NAME OF FATHER David Stumpner

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Annie Weaber

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant David Stumpner

(Address) 1916 W. Saratoga St

Filed APR 26 1929 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/24/1929

17

I HEREBY CERTIFY, That I attended deceased from April 22, 1929, to April 25, 1929, that I last saw h.. alive on April 25, 1929, and that death occurred, on the date stated above, at 7.35 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary embolism

(duration) 4 hours

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Removed ovaries Sept. Date of 4/22/29

Was there an autopsy? No

What test confirmed diagnosis? Physical exam.

(Signed) John Mace M.D.

, 19 (Address) Church Home + Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Western Cem. Apr 27 1929

20 UNDERTAKER ADDRESS

Thos. O. Mitchell & Son 1900 Eutaw Pl

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 45412 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. E 45412

REGISTERED NO. 57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3801 Greenmount Ave. ST., 9-47 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Lewis Engel

(a) RESIDENCE NO. 3801 Greenmount Ave. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret C. Engel

6 DATE OF BIRTH (month, day, and year) Aug. 15, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	73	8	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Gottlieb Engel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Annie M. Demar

13 BIRTHPLACE OF MOTHER (city or town) (State or country) France

14 Informant Mrs. Alexander Romans

(Address) 3801 Greenmount Ave.

15 APR 26 1929 19 HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 24, 1929

17

I HEREBY CERTIFY, That I attended deceased from Mar 23, 1929, to Apr 25, 1929,

that I last saw her alive on Apr 25, 1929

and that death occurred, on the date stated above, at 4.20 p. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

about

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Treated by another physician previous to my attendance

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Chemical analysis

(Signed) H. G. Prentiss, M. D.

, 19 (Address) 634 Gorsuch Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery Co

DATE OF BURIAL April 27 1929

20 UNDERTAKER John F. Denny

ADDRESS 715 Light St

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

Titomas

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45413

CERTIFICATE OF DEATH.

44

E 45413

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1620 Lexington ST. 19-2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Susan Thomas

(a) RESIDENCE NO. 1620 W. Lexington ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 31 1859

7 AGE: Years 70 Months 0 Days 24

If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Unknow

PARENTS

10 NAME OF FATHER: unknow

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknow

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknow

14 Informant (Address): maryland Baptist Home 622 W Lexington st

15 [illegible]

APR 26 1929

HAMILTON JONES, M. D. Registrar

By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/24 1929

17 I HEREBY CERTIFY, That I attended deceased from 1/1 1929, to 4/24 1929, that I last saw h[illegible] alive on 4/23 1929, and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of cervix

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

4/26 1929 (Address) 24 W Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Auburn

DATE OF BURIAL: April 26 1929

20 UNDERTAKER: Joseph A Lively

ADDRESS: 409 n mount st

TION is very important See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45414 E 45414

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Sinai Hospital

REGISTERED NO. 12B

CITY OF BALTIMORE: (No. Monument & Rutland ST., 15-54 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rebecca Miller

(a) RESIDENCE NO. 2266 Linden ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? 38 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Miller

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	65	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Burach-I. Rohnis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Dunkaun

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Benj Miller

(Address) 2266 Linden ave

15 Filed APR 26 1929 (Signed) HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/25 1929

17 I HEREBY CERTIFY, That I attended deceased from 4/22 1929 to 4/25 1929, that I last saw h alive on 4-25 1929, and that death occurred, on the date stated above, at 6.00A m.

The CAUSE OF DEATH* was as follows:

Coli-Cholecystitis & Septicemia.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Surgical Shock.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 4-24-29

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) B Cohen M. D.

19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rehrer Rosedale

DATE OF BURIAL 4/26 1929

20 UNDERTAKER Jack Levis

ADDRESS 1439 E Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Every question must be answered. TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 45415

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001 ✓ E 45415

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hosp. St. 1622 Ward)

2-FULL NAME Mattie V. Duncan.

(a) RESIDENCE NO. 1366 N. Calhoun St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Fmale	Col	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 17-1913

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	16	1	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Maid.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country)

PARENTS

10 NAME OF FATHER Thos Duncan

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Maggie Washington

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Maggie Duncan
(Address) 1366 N Calhoun

15 Filed 6-29 C. HAMPSON JONES, M. D.
Registrar

R 26 1529

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) April 24th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) None — Autopsy performed

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1366 N. Calhoun

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) H. Holland M. D.
Coroner
(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL 4/26/1929

20 UNDERTAKER Wm. Geo. H. Holland — ADDRESS 1631 Druid Hill Ave.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45416

1-PLACE OF DEATH

CERTIFICATE OF DEATH

90 E 45416

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of Baltimore: (No. 219 N. Paca St. 405 Ward)

2-FULL NAME Ella V. Wiseman

(a) RESIDENCE NO. 219 N. Paca St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Wiseman

6 DATE OF BIRTH (month, day, and year) March 11 - 1884

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	45	1	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work at home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto. Md

PARENTS

10 NAME OF FATHER Wm. Schaeffer

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Sarah Chrisall

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto. Md

14 Informant Wm. G. Schaeffer
(Address) 1516 E. Monument St

15 Filed ..... C. HAMPSON JONES, M. D. Registrar
Per

APR 26 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Tilley M. D.

4/25. 1929. (Address) 2739 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	April 28 1929

20 UNDERTAKER ADDRESS

Williams G. Schaeffer 1516 Monument

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 lkm.

E 45417 HEALTH DEPARTMENT—CITY OF BALTIMORE 100-00 E 45417

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. .....

CITY OF BALTIMORE: (No. 14 N. Glover St ST. 6-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rita Mary King

(a) RESIDENCE NO. 14 N. Glover St ST., ... WARD
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Child

3a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Jan 13, 1929

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓ (and)

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Charles P. King

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Anna J. King

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Mrs. King

(Address) 14 N. Glover St.

15 [illegible] 19 [illegible] C. HAMPSON JONES, M. D. Registrar

PR 26 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25 29

17 I HEREBY CERTIFY, That I attended deceased from April 5, 1929, to April 25, 1929, that I last saw h[illegible] alive on April 21, 1929 and that death occurred, on the date stated above, at 2 a, m.

The CAUSE OF DEATH* was as follows: Acute Bronchitis

(duration) ..... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ..... yrs. ..... mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Ph. Artigiani, M. D.

, 19 (Address) 2942 E. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL April 27, 1929

20 UNDERTAKER John A. Moran

ADDRESS 3000 E. Balto St

Spec.—1-12-23—M&T—500 Bks.

E 45418 HEALTH DEPARTMENT—CITY OF BALTIMORE E 45418

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 1150 N. Carey (ST.) 16-23 (WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hamer Gardner

(a) RESIDENCE NO. 1150 N. Carey ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Gardner

6 DATE OF BIRTH (month, day, and year) Aug. 3: 1857?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	71	8	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Keeper

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) Matthews Co (State or country) Va.

PARENTS

10 NAME OF FATHER Hamer Willis

11 BIRTHPLACE OF FATHER (city or town) Matthews Co (State or country) Va

12 MAIDEN NAME OF MOTHER Cordelia Lee

13 BIRTHPLACE OF MOTHER (city or town) Matthews Co (State or country) Va

14 Informant Robt A Brown (Address) 1150 N Carey

15 Filed 4/26/1929 C. HAMPSON JONES, M. D. Registrar

R261929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25 19 29

17 I HEREBY CERTIFY, That I attended deceased from April 23, 19 29, to April 25, 19 29, that I last saw h[illegible] alive on April 24, 19 29, and that death occurred, on the date stated above, at 6.35 A m.

The CAUSE OF DEATH* was as follows:

Goitre Carcinoma (duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Age - Arterio Sclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Gloucester Co Va,

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Wm H Wright M. D.

4/25/1929 (Address) 1209 Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Gloucester C. H. Va DATE OF BURIAL 4/26 19 29

20 UNDERTAKER Samuel L Hensley ADDRESS 538 N Bridge

CAUSE OF DEATH MUST be filled in plainly, without abbreviations. See instructions on back of certificates.
TION is very important

Spec.—2-29-28—L. F. S.—500 Bks.

Brocato.

E 45419

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

51 E 45419

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 8287 Entaw St. 11-24 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Adelina Theresa Brocato

(a) RESIDENCE NO. 8287 Entaw ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. 7 ds. 2 How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: white | 5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 2 1927

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
1	7	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER C. V. Brocato

11 BIRTHPLACE OF FATHER (city or town) (State or country): New Orleans

12 MAIDEN NAME OF MOTHER Annetta M. Giordano

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Charles Brocato

(Address): 824 Entaw St

15 Date Received: APR 26 1929

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24, 1929

17 I HEREBY CERTIFY, That I attended deceased from 4-18, 1929, to 4-24, 1929, that I last saw h.y alive on 4-24-, 1929 and that death occurred, on the date stated above, at 12.20 P. m.

The CAUSE OF DEATH* was as follows:

Rheumatic endocarditis - and otitis media.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Endocarditis -

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) S. Demarco, M. D.

4-26-29 (Address) Medical Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral

DATE OF BURIAL: April 27 1929

20 UNDERTAKER: Frank V. Petrone

ADDRESS: 2218 E. Baltimore

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

Quick

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 45420

CERTIFICATE OF DEATH

E 45420

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Willie Quick

(a) RESIDENCE NO. 712 N. Eden St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Quick

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Hugh Quick

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Eliza ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Records of

(Address) Baltimore City Hosp.

FILED APR 26 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 21, 19 29, to April 23, 19 29,

that I last saw him alive on April 23, 19 29

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X Ray

(Signed) Marvin Huff M. D.

19 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Calvary Cem.	April 26 1929
20 UNDERTAKER	ADDRESS
Robert E. Williams	1515 N. Eden St

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45421 HEALTH DEPARTMENT—CITY OF BALTIMORE E 45421

CERTIFICATE OF DEATH

+90

1—PLACE OF DEATH

REGISTERED NO. 28-63

CITY OF BALTIMORE: (No. Mt Hope Retreat ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Benj Scheuer (Benjamin Scheuer)

(a) RESIDENCE NO. Richmond, Va ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 7 mos. 10 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Dec 25. 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mt Hope Records (Address) Mt Hope Retreat

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

R 261929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 26. 1929

17 I HEREBY CERTIFY, That I attended deceased from April 5, 19 28, to April 26, 19 29, that I last saw h alive on April 25, 19 29 and that death occurred, on the date stated above, at 7.40 a m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis (Pulmonary Edema)

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Dementia

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Wallace P. Bell, M. D.

, 19 (Address) Mt Hop Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Richmond, Va — DATE OF BURIAL: Apr 26 19 29

20 UNDERTAKER: Wm J Tucker & Sons — ADDRESS: N. Y. Pa

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45422 HEALTH DEPARTMENT—CITY OF BALTIMORE E 45422

CERTIFICATE OF DEATH

90

1—PLACE OF DEATH

REGISTERED NO. 25-75

CITY OF BALTIMORE: (No. 1809 Morrell Pk Ave ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Vincent Valys

(a) RESIDENCE NO. 1809 Morrell Pk. Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Caroline

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Lithuania
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Lithuania
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Lithuania
(State or country)

14

Informant Mrs. Caroline Valys

(Address) 1809 Morrell Pk. Ave

Filed APR 26 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25, 1929

17

I HEREBY CERTIFY, That I attended deceased from April 10, 19 29, to April 25, 19 29, that I last saw him alive on April 25, 19 29 and that death occurred, on the date stated above, at 11:30 a. m.

The CAUSE OF DEATH* was as follows:

Apoplexy, followed by left hemiplegia

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Chronic Valvular Heart Disease (duration) Years yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) I. B. Bronushas, M. D.
I. B. Bronushas

APR 24, 1929 (Address) 3037 O'Donnell St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus	4-27-29

20 UNDERTAKER Chas. B. Kuchauckas ADDRESS 637 S. Paca

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 45423 HEALTH DEPARTMENT—CITY OF BALTIMORE 24-08 E 45423

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 207 E Preston ST 11-15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Nelson Marye

(a) RESIDENCE NO. 207 East Preston ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ late Elizabeth M. B. Marye

6 DATE OF BIRTH (month, day, and year) Sept. 7, 1841

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	87	7	18 17	

8 OCCUPATION OF DEACEASED

(a) Trade, profession or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Fredericksburg, Va.
(State or country)

PARENTS

10 NAME OF FATHER James Braxton Marye

11 BIRTHPLACE OF FATHER (city or town) Fredericksburg
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Jane Christian Gott

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Westmoreland County, Va.

14 Informant William B. Marye
(Address) 207 East Preston Street

15 Filed C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24th 1929

17

I HEREBY CERTIFY, That I attended deceased from April 23, 19 24, to April 25, 19 29,

that I last saw h.. alive on April 24, 19 29

and that death occurred, on the date stated above, at 5-50 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ✓ Date of

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) Chas. E. Benson, M. D.

4/24, 19 29 (Address) 1 Longwell Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	April 26 1929
20 UNDERTAKER	ADDRESS
Mary J. Jenkins & Sons Co	Orchard & Eutaw Sts

Important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 45424 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45424

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2359 Frederick Ave. (WARD) 10-69

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Renner

(a) RESIDENCE NO. 2359 Frederick Ave. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 4-25-29

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 10 min.
	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Joseph Theodore Renner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto.

12 MAIDEN NAME OF MOTHER Bessie Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant

(Address)

15 Filed 4/26 1929 C. HAMPSON JONES, M. D. 3516 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-25 1929

17 I HEREBY CERTIFY, That I attended deceased from 4/25 1929 to 4/25 1929, that I last saw her alive on 4-25-29 1929, and that death occurred, on the date stated above, at 3:10 A m.

The CAUSE OF DEATH* was as follows:

Asphyxia.
Accidental.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

(Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health.

ADDRESS APR 26 1929

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45425

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001

E 45425

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 811 E. 35th St. ST. 13 WARD)

REGISTERED NO. 13527

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Hattie V. Standiford

(a) RESIDENCE NO. 811 E. 35th St. ST., 13 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Howard Standiford

6 DATE OF BIRTH (month, day, and year) July 27-1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	59	8	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford Co. Md.

PARENTS

10 NAME OF FATHER Thomas Amoss

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Angeline Fatherly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Howard Standiford

(Address) 811 E. 35th St.

15

19

C. HAMPSON JONES, M. D.

Registrar

By

APR 26 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25 1929

17

I HEREBY CERTIFY, That I attended deceased from Dec 1, 19 28, to April 25, 19 29

that I last saw h[illegible] alive on April 25, 19 29

and that death occurred, on the date stated above, at 1:10 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Cardiac asthma

Chronic Nephritis (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) C. F. C. Engleman M. D.

4 Apr 19 29 (Address) 320 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	April 27 19 29
20 UNDERTAKER Horace M. Burgee	ADDRESS 363 Park Road

important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Eks.

E 45426

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45426

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3642 Beech Ave. St., 13 Ward) 13-29

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Charles E. Harper

(a) Residence No. 3642 Beech Ave St., 13 Ward.

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Widower

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Emma J. Harper

6-DATE OF BIRTH (month, day and year) Oct 22-1858

7-AGE. 70 yrs. 6 mos. 3 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Watchman

(b) General nature of industry, business, or establishment in which employed (or employer). 062

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Balto Co Md

PARENTS.

10-NAME OF FATHER. Unknown

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Unknown

12-MAIDEN NAME OF MOTHER. Unknown

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Unknown

11- (Informant). Clinton E. Harper

(Address). 3642 Beech Ave.

15- Filed. C. HAMPSON JONES, M. D. Registrar.

R 26 1929

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). April 25, 29

17- I HEREBY CERTIFY, That I attended deceased from April 1, 1929 to April 25, 1929

that I last saw him alive on April 24, 1929

and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Chronic Nephritis, Anemia of Lge. Imp.

Chronic Myocarditis

Duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(Duration) yrs. mos. 5 ds.

18-Where was disease contracted if not at place of death? Same

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) C. Hampson Jones, M. D.

April 25, 1929 (Address) 50 Chesapeake

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Olivet Friedlands

DATE OF BURIAL. April 27 1929

20-UNDERTAKER. Balto Co

ADDRESS. 3621 Kolb Rd

Horace H. Burgee

In plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 45427 (2459 1)

101-001 ✓

E 45427

1—PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO.

CITY OF BALTIMORE: (No.) ST., 6-9 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emory Thompson

(a) RESIDENCE NO. 403 N. Dallas ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	B.	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Bessie

6 DATE OF BIRTH (month, day, and year) 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N Car

PARENTS

10 NAME OF FATHER Neal

11 BIRTHPLACE OF FATHER (city or town) (State or country) N Car

12 MAIDEN NAME OF MOTHER Alice Pettiman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N Car

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 19 Registrar

C. HAMPSON JONES, M. D.

Page ... (Copied) ... Registrar

R261029 C W SHOP NOS. HAMILTON

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24-1929

17

I HEREBY CERTIFY, That I attended deceased from April 21, 1929, to April 24, 1929, that I last saw him alive on April 24, 1929 and that death occurred, on the date stated above, at 6.45 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? X-ray

(Signed) C. H. Jones, M. D.

19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lumberton N.C.	4-26 1929
20 UNDERTAKER Daniel Easton	ADDRESS 9/E Balto

Important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 45428 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 45428

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1504 Vine ST., 19-27 WARD)

2-FULL NAME Samuel Turner

(a) RESIDENCE NO. 1504 Vine ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced (or) WIFE of Elizabeth Turner

6 DATE OF BIRTH (month, day, and year) 1864?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	65	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer, Odd

(b) General nature of industry, business, or establishment in which employed (or employer) Oyster Shucker

(c) Name of employer unknown

9 BIRTHPLACE (city or town) (State or country) Maryland Balto. Sheep St.

PARENTS

10 NAME OF FATHER John Samuel Turner

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Emily Wilkins

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant Elizabeth Turner (Address) 1504 Vine St

15 4/26 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24 19 29

17

I HEREBY CERTIFY, That I attended deceased from March 23, 19 29, to April 24, 19 29, that I last saw him alive on April 20, 19 29, and that death occurred, on the date stated above, at 2.45 P. m.

The CAUSE OF DEATH* was as follows:

Fibroid Phthisis

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) John W. Knight, M. D.

4/26, 19 29 (Address) 1209 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL April 29 19 29

20 UNDERTAKER A. Jones

ADDRESS W. S. Gilmor

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 45429

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45429

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital ST. 15-59 (WARD)

2-FULL NAME Miss Wilhelmina Staib.

(a) RESIDENCE No. 1621 N. North Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 2 mos. 6 ds. How long in U. S., if of foreign birth? 50 yrs. 2 mos. 6 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Feb 20 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	2	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Adolph Staib

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mr. Elizabeth Staib

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Marie Staib

(Address) 1621 N. North Ave

15 C. HAMPSON JONES, M. D. . 19 Registrar

R 26 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-26 1929

17

I HEREBY CERTIFY, That I attended deceased from 4-14 , 1929 , to 4/26 , 1929 ,

that I last saw h alive on 4/26/ , 1929

and that death occurred, on the date stated above, at 10:40 a m.

The CAUSE OF DEATH* was as follows:

Endocarditis,

Pericarditis with Effusion,

Myocarditis, diphtheritic origin (Intercurrent)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical + Physical

(Signed) H. M. Forester , M. D.

, 19 (Address) St agnes Hosp Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudenhurst Cemetery	4/28/29.
20 UNDERTAKER Stewart Hoverd Co	ADDRESS Balto

CAUSE OF DEATH must be plainly written. See instructions on back of certificates.

TION is very important.

Spec. 2-29-28—L. F. S.—600 Bks.

E 45430

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 45430

1—PLACE OF DEATH

REGISTERED NO. .....

CITY OF BALTIMORE: (No. 307 Somerset Road, 7-53 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elmer Berry Jeffery

(a) RESIDENCE NO. 307 Somerset Road ST. ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Nellie W. Jeffery

6 DATE OF BIRTH (month, day, and year) Sept-9-1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	58	7	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Banker

(b) General nature of industry, business, or establishment in which employed (or employer) President of

(c) Name of employer Equitable Trust Co.

9 BIRTHPLACE (city or town) (State or country) Bel-Air Maryland

PARENTS

10 NAME OF FATHER Wm. S. Jeffery

11 BIRTHPLACE OF FATHER (city or town) (State or country) Harford Co Md.

12 MAIDEN NAME OF MOTHER Mary E. Keith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Harford Co Maryland

14 Informant Mrs Nellie W. Jeffery, Wife

(Address) 307 Somerset Road

15 Filed 4-26 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25-1929

17 I HEREBY CERTIFY, That I attended deceased from Mar ....., 1928, to April 25, 1929, that I last saw him alive on April 25, 1929 and that death occurred, on the date stated above, at 8-15 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage - Left Hemiplegia - Coma.

(duration) ..... yrs. ..... mos. 2½ ds.

CONTRIBUTORY (Secondary) Arteriosclerosis, Cardiac Vascular Renal Disease (duration) 1 yrs 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Paralysis + Coma

(Signed) M. Gibson Forlen, M. D.

4/26, 1929 (Address) 4822 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	April 27/1929.
20 UNDERTAKER	ADDRESS
Stewart & Co.	Balto.

Important. See instructions on back of certificate.

26 1929

Spec.—1-12-23—M&T—500 Bls.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45431

CERTIFICATE OF DEATH.

E 45431

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1622 Druid Hill Ave ST. 14-20 WARD

2-FULL NAME John H. Johnson

(a) RESIDENCE NO. Old Folks Home ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	colored	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Mamie Johnson

6 DATE OF BIRTH (month, day, and year) 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John H. Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mamie Booth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Cesie Johnson Graphin
(Address) 1102 N. Fatapsco St

15 APR 26 1929 C. HAMPSON JONES, M. D. Registrar
per MHB

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25 1929

17

I HEREBY CERTIFY, That I attended deceased from Nov. 4, 1928, to April 25, 1929, that I last saw h in alive on April 25, 1929, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edw. L. Wyatt, M. D.

(Address) 1228 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL Apr 27 1929

20 UNDERTAKER John H. Trader

ADDRESS 1029 Lemmon Hill

CAUSE OF DEATH in plain terms, so that it may be properly coded. TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 45432

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 45432

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 514 S. Fremont Ave ST., 21-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George A Wildermuth

(a) RESIDENCE NO. 514 S Fremont Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 61 yrs. — mos. — ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

(If non-resident give City or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE: Years 61 | Months — | Days — | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Shoe Maker

(b) General nature of industry, business, or establishment in which employed (or employer): Employed by

(c) Name of employer: Clement F. Ball

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: John Wildermuth

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Carrie Frank

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

11 Informant: Mrs. Mary E. Frey

(Address) 514 S Fremont Ave

15 Filed [illegible] 19 29 C. HAMPSON JONES, M. D. Registrar

APR 27 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 26 1929

17 I HEREBY CERTIFY, That I attended deceased from March 15 19 29, 19 ..., that I last saw him alive on April 26 19 29, and that death occurred, on the date stated above, at 2.30 A m.

The CAUSE OF DEATH* was as follows:

Nephritis, Chronic Parenchymatous

Renal Cirrhosis (duration) yrs. 1 mos. 1/2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis & Hypertension

Renal Cirrhosis (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? [illegible]

(Signed) [illegible], M. D.

(Address) 1 W Hoffman

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	Apr. 29 1929
20 UNDERTAKER: Henry Storck Sons Inc.	ADDRESS: 1301 E Eager St

important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

E 45433

HEALTH DEPARTMENT—CITY OF BALTIMORE

118-001

E 45433

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of BALTIMORE: (No.) Md. General Hospital (Ward) 15-61

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Emma J. Riggs.

(a) RESIDENCE NO. 2237 Windsor Ave. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Reuben Riggs.

6 DATE OF BIRTH (month, day, and year): 4/26/29

7 AGE: Years 89 Months Days 2 IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: G. H.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER John Jones

11 BIRTHPLACE OF FATHER (City or town) Balto.

(State or country)

12 MAIDEN NAME OF MOTHER Annie Watts

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant (Address) Hospital Records

15 Filed C. HAMPSON JONES, M. D. Registrar

Per

R 2 71929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/26 1929

17 I HEREBY CERTIFY, That I attended deceased from 4/12/29, 19, to 4/26/29, 19,

that I last saw her alive on 4/26/29, 19,

and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Strangulated femoral hernia

Intestinal obstruction.

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Dyspnoea due to obstruction.

(duration) yrs. mos 20 ds.

18 Where was disease contracted

if not at place of death? Home.

Did an operation precede death? yes. Date of 4/12/29

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

. 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Mont. Co. Md. Date of Burial: Jan 28 1929

20 UNDERTAKER: John C. Mitchell & Sons ADDRESS: 1900 Eutaw Place

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 45434

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45434

CERTIFICATE OF DEATH

90

1-PLACE OF DEATH

City of Baltimore: (No. St. Joseph Hospital St., 27-43 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alvenia Davis

(a) RESIDENCE NO. 610 Glenwood Ave St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F.	W	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Wm. G. Davis

6 DATE OF BIRTH (month, day, and year) About 1843

7 AGE Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
about 75			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Boston, Mass.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) "

14 Informant Mrs. Nellie E. Wade
(Address) Halethorpe, Md.

15 Filed ....., 19.....

R 27 1929

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 20/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema-Chr. Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible] M. D.

4/27/29 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL Apr 29 1929

20 UNDERTAKER Hughes & Townsend

ADDRESS 1421 Pond

tion should be carefully supplied. AGE should be stated EXACTLY. Prefix to OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 45435

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74 001

E 45435

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2117 Hollins ST. 20-69 WARD)

2-FULL NAME George A Smith

(a) RESIDENCE NO. 2119 Hollins ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. 9 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Kate Smith

6 DATE OF BIRTH (month, day, and year): July 6 48

7 AGE: Years 80 | Months 9 | Days 19 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Painter

(b) General nature of industry, business, or establishment in which employed (or employer): 65

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Bath Md.

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Kate Smith
(Address): 2117 Hollins St

15 Filed ..... C. HAMPSON JONES, M. D. Registrar
By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 25 1929

17 I HEREBY CERTIFY, That I attended deceased from July 24, 1928, to Apr 25, 1929, that I last saw him alive on Apr 22, 1929, and that death occurred, on the date stated above, at 7.15 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy —

(duration) yrs. 9 mos. ds.

CONTRIBUTORY (Secondary): Myocardial insufficiency

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) W B Bauernschmidt, M. D.

4/26, 1929 (Address) 626 N. Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Bene — DATE OF BURIAL: Apr 29 1929

20 UNDERTAKER: W M Routson — ADDRESS 2238 W Northern

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

R 2 11529

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45436 ✓ E 45436

CERTIFICATE OF DEATH

47

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Baltimore Co 404 ST., 1 WARD)

2—FULL NAME Mary Ball

(a) RESIDENCE NO. 613 S Eden ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer) Own

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Edna Thomas

(Address) 613 N. Eden st.

15 [illegible] 19 C. HAMPSON JONES, M. D. Registrar

Per [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/27/29

17 I HEREBY CERTIFY, That I attended deceased from 4/25 19 29, to 4/27 19 29, that I last saw h[illegible] alive on 4/27 19 29 and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast left

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) H. W. Yoe, M. D.

, 19 (Address) Balto & Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Archbyl Cemetery	Apr. 29 29
20 UNDERTAKER Mrs. R. G. Elliott	ADDRESS Eastland

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45437

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 45437

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1103 Argyle Ave ST.) (17-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mattie Jones

(a) RESIDENCE NO. 1103 Argyle Ave ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Col

5 Single, ~~Married~~, Widowed, or ~~Divorced~~, (write the word): Widow

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 16 90

7 AGE — Years: 38 | Months: 5 | Days: 8 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): Private

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Greensboro N. C

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: James Williams
(Address): Atlantic City N J

15 Filed: C. HAMPSON JONES, M. D. Registrar

By: [illegible]

2 7 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 24 - 29

17 I HEREBY CERTIFY, That I attended deceased from June 5 1928 to Apr 24 1929

that I last saw h[illegible] alive on Apr 23 1929

and that death occurred, on the date stated above, at 5-55 Am.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. 10 mos. 19 ds.

CONTRIBUTORY (Secondary) Dis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) B. N. Hatcher M. D.

4/27 1929 (Address) 1705 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: Apr 27 1929

20 UNDERTAKER: Wm M. Chase & Son — ADDRESS: 1400 Mosher

important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 45438

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45438

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 578 N Mary St. 17-24 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm H Bowen

(a) RESIDENCE NO. 578 N Mary St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Bertie Bowen

6 DATE OF BIRTH (month, day, and year): 1871

7 AGE: Years 58 | Months | Days | If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Bello Md

PARENTS

10 NAME OF FATHER: Henry Bowen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Belmont

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant: Bertie Bowen

(Address) 578 N Bradle

15 C. HAMPSON JONES, M. D., Registrar

Per

4 27 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/25 1929

17 I HEREBY CERTIFY, That I attended deceased from 4/14 1929 to 4/26 1929

that I last saw h alive on 4/25 1929

and that death occurred, on the date stated above, at 9:20 A m

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

4/26 1929 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Lawn — DATE OF BURIAL: 4/28 1929

20 UNDERTAKER: Samuel Saunders — ADDRESS: 578 N Bradle

CAUSE OF DEATH in plain terms, as much as possible. See instructions on back of certificates.

TION is very important

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45439

CERTIFICATE OF DEATH

90 E 45439

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. MORE CITY HOSPITALS ST. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Wesley Hart

(a) RESIDENCE NO. 207 W. Hoffman ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): ?.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ?.

6 DATE OF BIRTH (month, day, and year)

7 AGE: 78 Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: James

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Susan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Friends

(Address)

15 [illegible] 2 7 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-24-29

17 I HEREBY CERTIFY, That I attended deceased from 3-4, 1929, to 4-24, 1929, that I last saw him alive on 4-24, 1929, and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

Myocardial Insufficiency

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Physical Exam

What test confirmed diagnosis?

(Signed) Marvin M. Pollock, M. D.

BALTIMORE CITY HOSPITALS, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn

DATE OF BURIAL: 4 28 1929

20 UNDERTAKER: Samuel D. Hemsley

ADDRESS: 578 N. Bridle

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 45440 HEALTH DEPARTMENT—CITY OF BALTIMORE E 45440

CERTIFICATE OF DEATH.

118

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 637 W Lafayette Ave ST. 17-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lelia Phillips

(a) RESIDENCE NO. 637 W Lafayette Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ ~~(or)~~ WIFE of Herbert Phillips

6 DATE OF BIRTH (month, day, and year) — — 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Piney Point Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Piney Pt (State or country) Md

14 Informant Herbert Phillips

(Address) 637 W Lafayette Ave

15 H. HAMPSON JONES, M. D. Registrar

R 27 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25. 1929

17 I HEREBY CERTIFY, That I attended deceased from July ..., 1928, to April 24. 1929, that I last saw her alive on April 24, 1929, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Tumors Pharynx ~~uncertain~~ Probable thrombosis by the Bowel

(duration) 7 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Myocardosis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Lee Ellis M. D.

4/25. 1929 (Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Piney Pt St Mary Co Md — DATE OF BURIAL 4/29 1929

20 UNDERTAKER Samuel D Greenwood 978 N Eutaw — ADDRESS

mation should be carefully supplied, that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 45441

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45441

CERTIFICATE OF DEATH.

74-001

REGISTERED NO.....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1635 orleans ST. 6-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fannie Penny

(a) RESIDENCE. No. 1635 orleans ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Colord	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE Years 45 Months Days If LESS than 1 day, ...hrs. or ...min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House Work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C

PARENTS

10 NAME OF FATHER John Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C

12 MAIDEN NAME OF MOTHER Mary Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C

14 Informant Margrett Wilson
(Address) 1632 E. Mountmont st

15 [illegible] 19

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4 - 25 1929

17 I HEREBY CERTIFY, That I attended deceased from April 22nd, 1929, to April 25th, 1929, that I last saw her alive on April 24th, 1929, and that death occurred, on the date stated above, at 4.30 A m.

The CAUSE OF DEATH* was as follows:

Paralysis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Apoplexy

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Jacob L. Lehmann, M. D.

4/25, 1929 (Address) 30 S. B'way

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: asbury cemetery — DATE OF BURIAL: april 28 1929

20 UNDERTAKER Edward Bryan — ADDRESS 1631 orleans st

PR 27 1929

mation should be carefully supplied. All[illegible] should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Hks.

E 45442

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

146 E 45442

1-PLACE OF DEATH

City of Baltimore: (No.) Balt City Hospital St., 6-9 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jennett Turner

(a) RESIDENCE NO. 106 N Bond St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1901

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	27	10		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House Work
(b) General nature of industry, business, or establishment in which employed (or employer) Home
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md.

PARENTS

10 NAME OF FATHER James Turner

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Lemia Gregary

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant James Turner
(Address) 106 N. Bond st

15 Filed ..... 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Carcinoma Liver
Jaundice 2 Mos
Chronic

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Septicaemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 106 N Bond

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Microscopic Exam

(Signed) James H Taylor M. D.

4-26-1929 (Address) Tower Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: asbury cemetery — DATE OF BURIAL: April 27 1929

20 UNDERTAKER: Edward Ryan — ADDRESS: 651 Orleans St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

R 27 1929 C. HAMPSON JONES, M. D. Registrar

Spec.—1-12-23—M&T—500 Bks.

704

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45443

E 45443

CERTIFICATE OF DEATH.

124

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST. 10-14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Patricia Fox

(a) RESIDENCE NO. Preston & Valley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Thomas Fox

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridgit Fox

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Little Sisters of the Poor

(Address) Preston & Gilmor Sts

R 271929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27th 1929

17 I HEREBY CERTIFY, That I attended deceased from April 24, 1929, to April 27, 1929, that I last saw h— alive on April 26, 1929, and that death occurred, on the date stated above, at 5 30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Bright's disease

Contributory (duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Edward Wyatt M. D.

4/29/1929 (Address) 1216 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL April 29 1929

20 UNDERTAKER Rita Wiedefeld — ADDRESS 914 Gramont Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Particular attention is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

E 45444

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-101

E 45444

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 7 Penna St. 4-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy Goode

(a) RESIDENCE NO. 7 Penna St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: David Goode

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 75 Months Days

IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (City or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: C. C. Goode

(Address): 7 Penna St.

15 Filed: C. HAMPSON JONES, M. D. Registrar

R 2 7 1929 Per: R.A.H.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-24 1929

17 I HEREBY CERTIFY, That I attended deceased from April 21, 1929, to April 24, 1929, that I last saw her alive on April 23, 1929, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) 1 yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) T. Scott Hammond, M. D.

, 19 (Address) 1102 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Evergreen Cemetery

Date of Burial: April 27, 29

20 UNDERTAKER: Leonard Wheeler

ADDRESS: 698 Penna Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—600 Bks.

E 45445

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 45445

1—PLACE OF DEATH

REGISTERED NO. 27-55

CITY OF BALTIMORE: (No. 6210 Park Heights ST. Ave. WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Archibald Sykes

(a) RESIDENCE NO. 6210 Park Heights ST Ave. WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rhoda C. Sykes

6 DATE OF BIRTH (month, day, and year) June 12, 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	10	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Attorney

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Jacob Sykes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. R. C. Sykes

(Address) 6210 Pk. Hgts Ave.

15 Filed APR 2 7 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26, 1929.

17 I HEREBY CERTIFY, That I attended deceased from January 3, 1929, to April 26, 1929, that I last saw him alive on April 26, 1929 and that death occurred, on the date stated above, at 8.20 P. m.

The CAUSE OF DEATH* was as follows:

Hypertension with Coronary Occlusion

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial dilatation

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Samuel Wolman, M. D.

, 19 (Address) Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balt. Hebrew Cem.	4/28/ 1929

20 UNDERTAKER David Goodman

ADDRESS 416 20 W. Mt. Royal Ave

OF DEATH in plain terms, so that important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 45446

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45446

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Temple Garden Apts. ST., 1905 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Manes A. Fuld

(a) RESIDENCE NO. Trenton, N.J. ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 20, 1863.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	9	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore.
(State or country) Md.

PARENTS

10 NAME OF FATHER Abraham Fuld

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Esther Hamburger

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mr. Jonas Fuld
(Address) Trenton, N.J.

15 Filed APR 27 1929, 19 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25th. 1929.

17 I HEREBY CERTIFY, That I attended deceased from January 4th, 1929, to April 25th, 1929, that I last saw h.... alive on April 2, 19.., and that death occurred, on the date stated above, at 10:30 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) — yrs. — mos. 14 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

Symptoms (duration) — yrs. 5 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Louis P. Hamburger, M. D.

April 26, 1929 (Address) 1207 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship Cem.	4/28/ 1929

20 UNDERTAKER Abrid Sondheim ADDRESS 118-20 W. Mt. Royal Ave.

Duplicate Certificate of Death must be filed before burial or removal. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45447

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

45 E 45447

1—PLACE OF DEATH University Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. 4-30 ST., 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Raulinas Lutskus

(a) RESIDENCE NO. 637 W. Lombard ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if foreign birth? 27 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marcele

6 DATE OF BIRTH (month, day, and year) No 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
57				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) Own

(c) Name of employer No.

9 BIRTHPLACE (city or town) (State or country) Lithvania

PARENTS

10 NAME OF FATHER Thom Lutskus

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithvania

12 MAIDEN NAME OF MOTHER No.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithvania

14 Informant Marcele Lutskus

(Address) 637 W Lombard Street

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

R 2 71929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26-29

17

I HEREBY CERTIFY, That I attended deceased from March 27, 1929, to April 26, 1929, that I last saw him alive on April 25, 1929, and that death occurred, on the date stated above, at 4.00 A m.

The CAUSE OF DEATH* was as follows:

*Carcinoma of rectum

(duration) yrs. 5 (?) mos. ds.

CONTRIBUTORY (Secondary) Septicemia & myocarditis

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of 4-2-29

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) P. H. Lemmon, M. D.

4/26 1929 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	April 29. 1929
20 UNDERTAKER	**ADDRESS**
John Grebliauckas & Co.	423 S Paca St.

IMPORTANT. See instructions on back of certificates. OF DEATH in plain terms, so that it may be properly

Cor.—10-10-29—A Co.—100 Bks.

E 45448

HEALTH DEPARTMENT—CITY OF BALTIMORE

185 E 45448

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of Baltimore: (No. South Baltimore General Hospital 5-8 Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George Phelps.

(a) RESIDENCE NO. 198 N. Gay St. St., Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	61	----------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Iron worker.
(b) General nature of industry, business, or establishment in which employed (or employer) 079
(c) Name of employer

9 BIRTHPLACE (city or town) Connecticut.
(State or country)

PARENTS

10 NAME OF FATHER Maro Phelps.

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Connecticut.

12 MAIDEN NAME OF MOTHER Alice Beer.

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Ohio.

14 Informant Daniel Scanlon.
(Address) 201 N. Gay St.

15 Filed ..... 19 C. HAMPSON JONES, M. D. Registrar

APR 27 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull.
Accidental fall from a platform.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? McComas, St. Piers. April 25, 1929

Did an operation precede death? No. Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Diagnosis.

(Signed) H. M. Hemmeter, M. D.

4/27. 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Middletown, Conn

DATE OF BURIAL 4/29/29

20 UNDERTAKER J. J. Staley & Sons

ADDRESS 818 E. Lexington St.

N. B.—WRITE PLAINLY with pen and ink. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45449 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 45449

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Baltimore City Hospitals ST., (B-13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harry Richardson (Richards)

(a) RESIDENCE NO. 802 N. Durham st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Separated

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Texas

PARENTS

10 NAME OF FATHER Charles Richardson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Texas

12 MAIDEN NAME OF MOTHER Annie Daniel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Texas

14 Informant Hospital Records

(Address)

15 Filed [illegible], 19 [illegible] R. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 26, 1929, to April 25, 1929, that I last saw him alive on April 25, 1929 and that death occurred, on the date stated above, at 12.45 a. m.

The CAUSE OF DEATH* was as follows:

Septic pneumonia due to

Vincent's-like organisms.

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical and autopsy

(Signed) Henry C. Smith, M. D.

4-25-19 29 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Washington D.C.	Apr. 27 1929
20 UNDERTAKER	ADDRESS
Wm. H. Elliott	1725 Ashland Ave

OF DEATH in plain terms, so that it may be properly important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 45450 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 45450

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Franklin Sq. Hosp ST., ... WARD

2-FULL NAME Mrs. Julia Donaldson

(a) RESIDENCE NO. ..... Laurel, Md ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 19 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Donaldson

6 DATE OF BIRTH (month, day, and year) September

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	21	8	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hair dresser

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Julia Donaldson

9 BIRTHPLACE (city or town) (State or country) Laurel, Md.

PARENTS

10 NAME OF FATHER Brad. Allen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Oklahoma

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Frank Donaldson

(Address) Laurel, Md.

15 C. HAMILTON JONES, M. D.

19 Per ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28 1929

17 I HEREBY CERTIFY, That I attended deceased from April 9, 1929, to April 28, 1929, that I last saw h[illegible] alive on April 28, 1929, and that death occurred, on the date stated above, at 3:15a m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

Septicemia

(Both following appendectomy and lobar (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? clinical picture

(Signed) Arthur Rattenni, M. D.

4/28/1929 (Address) Franklin Sq. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Ivy Hill | DATE OF BURIAL April 30 1929

20 UNDERTAKER Elwood R. Fisher | ADDRESS Laurel, Md.

PR2 81929

mation should be carefully supplied. AGE should be stated EXACTLY. If CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45451

CERTIFICATE OF DEATH.

66 ✓

E 45451

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1008 Boyd St. 16-29 Ward)

2-FULL NAME Margaret Applin

(a) RESIDENCE NO. 1008. Boyd St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ed. Applin

6 DATE OF BIRTH (month, day, and year) Aug. 15- 1878

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
50	5 1	8	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work W. W. 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER Valentine G. Kessner

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany.

12 MAIDEN NAME OF MOTHER Elizabeth Fischer

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant George A. W. Kessner

(Address) 608 Glendale Ave

Filed APR 28 1929 G. HAMPSON JONES, M. D.

Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 26 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) Charles W. Brooke M. D.

4/27, 1929 (Coroner) (Address) 5 W. Lint Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

New Cathedral Cemetery April 29-1929

20 UNDERTAKER ADDRESS

Mr. Thos. John K. Feusel & Son 804 W. Fayette St

NOTE—Where certificate is not complete in every particular, it will be returned for correction. AGE should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

124 21 7
E 45452

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 45452

1—PLACE OF DEATH JOHNS HOPKINS HOSPITAL

REGISTERED NO. 50

CITY OF BALTIMORE: (No. ... ST., 9-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Stassinos

(a) RESIDENCE NO. 14 Queen St- ST., WARD Hampton 2a-
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. 1 mos. ... ds. How long in U. S., if foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9 BIRTHPLACE (city or town) (State or country) Greece

PARENTS

10 NAME OF FATHER Angelo Stassinos

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greece

12 MAIDEN NAME OF MOTHER Helen Gudas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Greece

14 Informant Friends
(Address) JOHNS HOPKINS HOSPITAL

15 Filed ... 19... HAMPSON JONES, M. D.
Registrar

APR 28 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27. 29

17 I HEREBY CERTIFY, That I attended deceased from Apr. 9 ... 1929, to April 27 ... 1929, that I last saw him alive on April 27 ... 1929 and that death occurred, on the date stated above, at 7:00 a. m.

The CAUSE OF DEATH* was as follows:

Echino-coccus cysts of Liver
secondary infection - forming Liver Abscess with rupture & Generalized Peritonitis - Cardiac failure

CONTRIBUTORY (duration) 1 yrs. ? mos. ... ds.
(Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Not determined

Did an operation precede death? Yes Date of Apr 25, 1929

Was there an autopsy? Yes

What test confirmed diagnosis? ...

(Signed) Ben D. Massey, M. D.

4/27 1929 (Address) Johns Hopkins Hosp. Balt. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hampden Road Va

DATE OF BURIAL 4/28 1929

20 UNDERTAKER Robert Brooks & Son

ADDRESS Calhoun Hollins sts

IMPORTANT. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45453

CERTIFICATE OF DEATH.

65-081

E 45453

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) Johns Hopkins Hos. (Ward) 8-40

2-FULL NAME Charles Warner Slyke

(a) RESIDENCE NO. 3171 Ravenwood Ave Ward F

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Slyke

6 DATE OF BIRTH (month, day, and year) Nov. 15 1884

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	44	5	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dry Goods Store

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) Essex Co. Va

(State or country)

PARENTS

10 NAME OF FATHER Leland Slyke

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Margaret Davis

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Mrs. Mary E. Slyke

(Address) 3171 Ravenwood Ave

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

PR 281929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 26 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Lymphoid Leukemia

(Autopsy At Hopkins)

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

(duration) ....yrs. ....mos. ....ds.

(Signed) ..... M. D.

(Coroner)

4/27/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem. Date of Burial Apr. 27 1929

20 UNDERTAKER Wm. J. Tickner & Sons ADDRESS North & Pa

N. B.—WRITE PLAINLY, with ink. Information required by law should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45454

CERTIFICATE OF DEATH

E 45454

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 3307 Abell Ave. WARD) REGISTERED NO. 90

2—FULL NAME Laura E. Horpel

(a) RESIDENCE NO. 3307 Abell Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 71 yrs. 2 mos. 20 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Divorced

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Horpel

6 DATE OF BIRTH (month, day, and year) Mar. 6. 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	71	2	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John N. Marsden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Eliza Ecton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant M. Albert Burns

(Address) 352 E. University Pkwy

15 [illegible] G. HAMPSON JONES, M. D.

Registrar

APR 28 1929

OF DEATH in plain terms, so that it may be properly classified. important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26, 1929

I HEREBY CERTIFY, That I attended deceased from April 25, 1929, to April 26, 1929, that I last saw h[illegible] alive on April 26, 1929 and that death occurred, on the date stated above, at 1155 a m.

The CAUSE OF DEATH* was as follows:

Myocarditis chronic

(duration) 15 yrs. mos. ds.

CONTRIBUTORY (Secondary) x

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? x

Did an operation precede death? no Date of x

Was there an autopsy? no

What test confirmed diagnosis? x

(Signed) C. Van Williams, M. D.

, 19 (Address) 601 Cumberland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem.	Apr 29 1929
20 UNDERTAKER	ADDRESS
Wm Flickner & Sons	North Ave

Spec.—2-29-28—L. F. S.—500 Bks.

E 45455

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 45455

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 15-68

CITY OF BALTIMORE: (No. 2855 W. Northern ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Francis O. Bilson

(a) RESIDENCE NO. 2855 W. Northern ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. — mos. 5 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

6a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Clara Bilson

6 DATE OF BIRTH (month, day, and year) April 21-1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	—	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Plumber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Andrew Bilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Lucy Welsh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Regina K. Meister

(Address) 2509 Liberty Heights Ave

15 Filed R 2 8 1929 T. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26-1929

17 I HEREBY CERTIFY, That I attended deceased from April 9, 1929, to April 26, 1929, that I last saw h— alive on April 26, 1929 and that death occurred, on the date stated above, at 2.50 p m.

The CAUSE OF DEATH* was as follows:

Acute Parenchymatous Nephritis

& Chronic Myocarditis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Albuminuria & Irregular Heart

(Signed) Thos. F. Mullikin, M. D.

, 19 (Address) 2300 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	Apl. 29 1929
20 UNDERTAKER Harry W. Ehlen	ADDRESS 1944 W. Northern

OF DEATH is particularly important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 45456

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 45456

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5007 Litchfield & ST., 27-56 WARD)

2-FULL NAME Henry Lowy

(a) RESIDENCE NO. 5007 Litchfield & ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? 47 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Celia Lowy

6 DATE OF BIRTH (month, day, and year) Dec 27, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
71	4	2	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Glass Cutter

(b) General nature of industry, business, or establishment in which employed (or employer) ....

(c) Name of employer employed by self.

9 BIRTHPLACE (city or town) (State or country) Homa, Russia

PARENTS

10 NAME OF FATHER Baer Lowy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Wife of deceased 5007 Litchfield &

15 Filed ..... 19.. C. HAMPSON JONES, M. D. Registrar

PR 28 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28 19 29

17 I HEREBY CERTIFY, That I attended deceased from April 14, 19 29, to April 27, 19 29, that I last saw h alive on April 27, 19 29, and that death occurred, on the date stated above, at 4.0 m.

The CAUSE OF DEATH* was as follows:

Myocarditis -

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. 2 mos. 14 ds.

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No -

What test confirmed diagnosis?

(Signed) Joseph Sudler, M. D.

19 (Address) 2348 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Wilson Mordals — DATE OF BURIAL 4-28-1929

20 UNDERTAKER Jack Levin — ADDRESS 1431 E Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. If infant, state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45457

CERTIFICATE OF DEATH

31

E 45457

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 1010 Wilmington Ave (STREET) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank. J. Blazek

(a) RESIDENCE NO. 1010 Wilmington Ave ST.

(Usual place of nbode)

WARD

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Blazek

6 DATE OF BIRTH (month, day, and year) Dec 19 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or .... min.
	49	4	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer) Helper

(c) Name of employer B. O. R Road

9 BIRTHPLACE (city or town) (State or country) Hungary

PARENTS

10 NAME OF FATHER Joseph Blazek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hungary

12 MAIDEN NAME OF MOTHER Elen Sponar

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hungary

14 Informant Mrs Mary Blazek

(Address) 1010 Wilmington Ave

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

By

R 281929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb 4 1929, to April 27 1929, that I last saw h alive on April 26 1929 and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 2 mos. 3 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) yrs. 2 mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Dr Bond, M. D.

19 (Address) 2229 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery Co	April 30 1929
20 UNDERTAKER	ADDRESS
Jos Jacobs & Son	207 S. Paca

OF DEATH in plain terms, so that it may be properly classified. important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 45458

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

E 45458

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, No. 2016 McCulloh St. (WARD) 14-20

2-FULL NAME Caroline Bryan

(a) RESIDENCE No. 2016 McCulloh ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	80			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER James Edwards

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Harriet Saunders

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Alice Edwards

(Address) 2016 McCulloh St

15 [illegible] C. HARRISON JONES, M. D. Registrar

R2 81929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 26 1929

17 I HEREBY CERTIFY, That I attended deceased from March 30, 1929, to Apr 25 1929

that I last saw him alive on Apr 25 1929

and that death occurred, on the date stated above, at 8 a m

The CAUSE OF DEATH* was as follows:

Chr. Interstitial nephritis ?

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) S. B. Hughes, M. D.

(Address) 1413 Druid Hill Ave

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL 4/29 1929

20 UNDERTAKER Saml J Hemsley ADDRESS 5781 Reisterstown Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

mation should be carefully supplied. AGE should be given for CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

224541 E 45459

CERTIFICATE OF DEATH

90

E 45459

REGISTERED NO.

1—PLACE OF DEATH Johns Hopkins Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST. 8-16 WARD)

2—FULL NAME Florence Criscuolli

(a) RESIDENCE NO. 1969 Patterson Park Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	single

a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 3-24-14

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	15	1	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schoolgirl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Battista

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Lolina Bova

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed APR 28 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27-1929

17 I HEREBY CERTIFY, That I attended deceased from April 19, 1929, to April 27, 1929, that I last saw h alive on April 27, 1929, and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Rheumatic Heart Disease -

4 yrs. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: Apr 29 1929

20 UNDERTAKER: Frank Graceffo — ADDRESS: 1906 Eastern Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause of death very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 45460

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 45460

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: (No.) Caton & Wilkens Aves. (WARD) 25-W

2-FULL NAME George W. Thompson

(a) RESIDENCE NO. Ellicott City Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible] 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	3	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work News paper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Howard Co. Md

PARENTS

10 NAME OF FATHER Samuel Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Howard Co. Md

12 MAIDEN NAME OF MOTHER Sarah Barnes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mary Thompson

(Address) 904 N. Charles St City

15 Filed [illegible] 19 C. HAMPSON JONES, M. D. Registrar

By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 28 1929

17 I HEREBY CERTIFY, That I attended deceased from Apr. 17, 1929, to April 28, 1929, that I last saw him alive on April, 28, 1929, and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Endocarditis,

Myocarditis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Apr. 18, 1929

Was there an autopsy? yes

What test confirmed diagnosis? Physical Examination

(Signed) H. M. Coleson, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL/REMOVAL Ellicott City Cem. DATE OF BURIAL Apr. 30 1929

20 UNDERTAKER Easton Jones ADDRESS Ellicott City

APR 28 1929

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45461 — CERTIFICATE OF DEATH — 90 — E 45461

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1403 E. Biddle ST. 10-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Melissa J. Warner

(a) RESIDENCE NO. 1403 E. Biddle ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert N. Warner

6 DATE OF BIRTH (month, day, and year) May 30 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	79	10	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Wren

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Jas. P. Warner

(Address) 1114 S. Eutaw St.

R 28 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 - 1929

17 I HEREBY CERTIFY, That I attended deceased from Mar. 17 - 1929, to April 27 - 1929, that I last saw h alive on 26 1929 and that death occurred, on the date stated above, at 5 15 a. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edwin B. Fenby M. D.

4/27/1929 Address 1223 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Cemetery	4/29 1929
20 UNDERTAKER	ADDRESS
Chas. S. Ward & Son	1180 W. Baltimore St

OF DEATH in plain terms, so that it may be properly classified. All items are important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 45462 HEALTH DEPARTMENT—CITY OF BALTIMORE E 45462

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Sinai Hosp. REGISTERED NO. 172

CITY OF BALTIMORE: (No. Monument ST. 1623 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances C Ford.

(a) RESIDENCE NO. 700 N Carey ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) 15 Oct 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
58 59	6	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work nothing

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Ford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mass

12 MAIDEN NAME OF MOTHER Mary Stevens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant William J Ford

(Address) 5321 Reisterstown Rd

C. HAMPSON JONES, M. D. Registrar

PR 2 81929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26 1929.

17 I HEREBY CERTIFY, That I attended deceased from April 25. 1929. to April 26. 1929.

that I last saw h alive on April 26. 1929.

and that death occurred, on the date stated above, at 4:10 m.

The CAUSE OF DEATH* was as follows:

Cirrosis of liver with jaundice and Cholemia.

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Arterio-sclerosis ? cardio vascular disease

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? yes.

What test confirmed diagnosis? Lab - Clinic

(Signed) Herman Chor M. D.

, 19 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL April 27 1929

20 UNDERTAKER Jaenah Syfer

ADDRESS Martin

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45463 · HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 100 006 E 45463

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Bethesda City Hospital ST.) 5-8 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thomas J Brien

(a) RESIDENCE NO. Sevens house ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Mike O'Brien

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Hospital Records
(Address)

15 APR 23 1929 HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-26-29

17 I HEREBY CERTIFY, That I attended deceased from 1-5, 1924, to 4-26, 1929, that I last saw him alive on 4-25, 1929 and that death occurred, on the date stated above, at 5 45 P.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John E. Moran, M. D.

, 19 (Address) Balto City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart — DATE OF BURIAL 4/28 1929

20 UNDERTAKER John J Fahey Sons — ADDRESS 1318 Light

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-00 45464

CERTIFICATE OF DEATH.

45464 E

E 45464 REGISTERED NO.

1-PLACE OF DEATH The Church Home and Inf. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

City of BALTIMORE: (No. ____ St., 7-14 Ward)

2-FULL NAME Mrs. Annie Reisinger

(a) RESIDENCE NO. 805 N. Streeper St. ____ Ward ____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Reisinger

6 DATE OF BIRTH (month, day, and year): April 13. 1893.

7 AGE: Years 36 | Months | Days 14 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore
(State or country)

PARENTS

10 NAME OF FATHER: John J. Evans

11 BIRTHPLACE OF FATHER (city or town): Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER: Evelyn Ferguson

13 BIRTHPLACE OF MOTHER (city or town):
(State or country): Balto

14 Informant: John Reisinger
(Address) 805 N. Streeper

15 Filed ____ 19 ____ C. HAMPSON JONES, M. D. Registrar
Per ____

APR 28 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 27 1929

17
I HEREBY CERTIFY, That I attended deceased from April 24 19..., to April 27, 19..., that I last saw h.. alive on April 27 19..., and that death occurred, on the date stated above, at 11.53 P. m.

The CAUSE OF DEATH* was as follows:
Pyelitis

(duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary): Lobar Pneumonia

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted
If not at place of death
Did an operation precede death? No Date of
Was there an autopsy? No.
What test confirmed diagnosis? Urine Examination

(Signed) Fred R. Landen, M. D.
, 19 (Address) The Church Home & Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cem. — Date of Burial April 1929

20 UNDERTAKER: John Ulrich — ADDRESS 2008 Eden

N.B.—WRITE PLAINLY, WITH UNFADING INK. THIS IS A LEGAL DOCUMENT. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45465

CERTIFICATE OF DEATH

E 45465

REGISTERED NO. 45465

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 511 N Clinton ST. 26-11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lewis C Stoffel

(a) RESIDENCE NO. 511 N Clinton ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna D. Stoffel

6 DATE OF BIRTH (month, day, and year): July 20, 1860

7 AGE — Years: 68. Months: 9 Days: 6 If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Printer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Henry Stoffel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Dora Ehrt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Annie D. Stoffel

(Address) 511 N Clinton

15 C. HAMPSON JONES, M. D.

APR 28 1929

19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 26-1929

17 I HEREBY CERTIFY That I attended deceased from Oct 10 1928 to Apr 26 1929

that I last saw h alive on Apr 26 1929

and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. da.

CONTRIBUTORY (secondary) Arteriosclerosis Chronic Nephritis

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Gross Appearance

(Signed) C. Hampson Jones, M. D.

(Address) 112 W. 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem

DATE OF BURIAL: Apr 30 1929

20 UNDERTAKER: Jos Ulrich

ADDRESS: 2008 Eden

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45466 ✓ 45766

CERTIFICATE OF DEATH

119

E 45466

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME, instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 507 N Highland Ave ST. 16-11 WARD)

2—FULL NAME Mary E Kelly

(a) RESIDENCE NO. 507 N. Highland Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced. (write the word) Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of William E Kelly

6 DATE OF BIRTH (month, day, and year) Oct 13-1871

7 AGE Years 57 Months 6 Days 23 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) 637

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Caspar Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sophia Horino

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant William E Kelly

(Address) 507 N Highland Ave

15 [illegible] C. HAMPSON JONES, M. D. Registrar

APR 28 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26/29.

17 I HEREBY CERTIFY, That I attended deceased from Feb 15, 1929, to April 26, 1929,

that I last saw h alive on April 26, 1929

and that death occurred, on the date stated above, at 11.50 m.

The CAUSE OF DEATH* was as follows:

Diverticulitis of Jejunum with perforation & Peritonitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Feb 24 1929.

Was there an autopsy? Yes.

What test confirmed diagnosis? autopsy.

(Signed) Abram Rynd, M. D.

, 19 (Address) #316 Medical arts Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem

DATE OF BURIAL Apr 30 1929

20 UNDERTAKER John Ulrich

ADDRESS 2008 Orleans

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45467

CERTIFICATE OF DEATH

31

E 45467

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Emerald First. ST. 11-30 WARD)

2—FULL NAME Joseph Mosley

(a) RESIDENCE NO. 635 W. Conway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Married

6 DATE OF BIRTH (month, day, and year): Nov 22, 1889

7 AGE: Years 39 | Months 5 | Days 3 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Calvert Co. Md

PARENTS

10 NAME OF FATHER: Elliott Mosley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Calvert Co. Md.

12 MAIDEN NAME OF MOTHER: Linda Camel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Calvert Co Md

14 Informant: Caroline Benton

(Address) 635 W. Conway ststt

C. HAMPSON JONES, M. D.

Filed APR 29 1929 19 Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 25, 1929.

17 I HEREBY CERTIFY, That I attended deceased from 4-23, 1929, to 4-25, 1929.

that I last saw him alive on 4-25, 1929

and that death occurred, on the date stated above, at 6:30 P. m.

The CAUSE OF DEATH* was as follows:

Diffuse pneumonia right lung. 60 hrs

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical.

(Signed) [redacted] M. D.

. 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary Cemtery

DATE OF BURIAL: 4/27 1929

20 UNDERTAKER: Walter B. Spicer

ADDRESS: 1514 N. Stanley St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45468

CERTIFICATE OF DEATH.

31 E 45468

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1348 N. Fremont ave ST., 15-20 WARD)

2-FULL NAME Louise Veronica Pearson

(a) RESIDENCE No. 1348 N. Fremont ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Pearson

6 DATE OF BIRTH (month, day, and year) Jan 13-1907

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	3	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Maid

(c) Name of employer Mrs Rosenthal

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Joseph Walker

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C. Raleigh

12 MAIDEN NAME OF MOTHER Mary Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Annapolis Anne Arundel Co Md

14 Informant (Address) Doalina Marshall 1348 N. Fremont ave

15 Filed APR 29 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26 19 29

17 I HEREBY CERTIFY, That I attended deceased from Feb 28 19 29 to April 26 19 29

that I last saw h alive on April 26 19 29

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis (Cavity Left Lung)

(duration) ? yrs. ? mos ? ds.

CONTRIBUTORY (Secondary) Miscarriage

6 ? (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) William J. Knight M. D.

4/27 19 29 (Address) 1209 Park ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters Cemetery	4-30 19 29
20 UNDERTAKER George T. A. Gibson	ADDRESS 1733 Lorena Hilton

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45469

CERTIFICATE OF DEATH

E 45469

REGISTERED NO. 129

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

City of BALTIMORE: (No. 940 Druid Hill Ave St., 17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Samuel Cramer

(a) RESIDENCE NO. 946 Druid Hill Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
male	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Cramer

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE 68 Years — Months — Days IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) Md

(State or country)

PARENTS

10 NAME OF FATHER Samuel Cramer

11 BIRTHPLACE OF FATHER (City or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER Jamie Brandon

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant Mary Cramer

(Address) 946 Druid Hill Ave

C. HAMPSON JONES, M. D.

Registrar

APR 29 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-26 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb 20, 1929, to April 26, 1929, that I last saw h alive on April 26, 1929, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Cardio Vascular Renal Disease

(duration) yrs 2 mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted

If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) J. H. Anderson, M. D.

, 19 (Address) 1202 Druid Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — Date of Burial Apr 29 1929

20 UNDERTAKER John H. Toadvine — ADDRESS 1027 Druid Hill

Spec.—2-29-28—L. F. S.—500 Bks.

Jones

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45470

CERTIFICATE OF DEATH

E 45470

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Patterson Park Ave 1705 St.) (WARD)

2—FULL NAME Wesley Jones

(a) RESIDENCE NO. 506 N Broad ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary B. Jones

6 DATE OF BIRTH (month, day, and year): Nov 1877

7 AGE: Years 51 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): ?

(c) Name of employer: ?

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: ?

11 BIRTHPLACE OF FATHER (city or town) (State or country): ?

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ?

14 Informant: Mary B. Jones
(Address) 506 Broad St

15 Filed APR 29 1929

C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-27-29

17 I HEREBY CERTIFY, That I attended deceased from 4-2, 1929, to 4-27, 1929 that I last saw h M alive on 4-27, 1929 and that death occurred, on the date stated above, at 0 50 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

Peritonitis (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & X Ray

(Signed) John E. Regan, M. D.

, 19 (Address) Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: Apr 30 1929

20 UNDERTAKER: John H. Toadvine — ADDRESS 1027 Wood St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45471

CERTIFICATE OF DEATH.

108 **E 45471**

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE—No. 1007 N. Stricker St. 16-22 WARD)

2-FULL NAME Roberta C. Hawkins

(a) RESIDENCE No. 1007 N. Stricker ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles S. Hawkins

6 DATE OF BIRTH (month, day, and year) Aug 23, 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29	8	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) Cleaning man etc

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Northumberland Co Va

PARENTS

10 NAME OF FATHER Geo Campbell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Charlotte Washington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) Charles Hawkins 1007 N Stricker St

15 Filed APR 29 1929 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 1929

17 I HEREBY CERTIFY, That I attended deceased from April 24, 1929, to April 27, 1929, that I last saw her alive on April 27, 1929 and that death occurred, on the date stated above, at 6.35 A. m.

The CAUSE OF DEATH* was as follows:

Septicaemia

(duration) yrs. ..... mos 13 ds.

CONTRIBUTORY (Secondary) Pyorrhoea

(duration) 1 yrs. ? mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Wm N. Wright, M. D.

4/27/29 (Address) 1709 Presstman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lottsburg, Va. Burial DATE OF BURIAL 4/29/1929

20 UNDERTAKER Jos. H. Holland ADDRESS 1631 Druid Hill

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45472 HEALTH DEPARTMENT—CITY OF BALTIMORE **E 45472**

21

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1514 N Wolfe ST., 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Augusta R. Stricker

(a) RESIDENCE NO. 1514 N Wolfe ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 21-1864

7 AGE: Years 65 | Months 3 | Days 7 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer): 00

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore.

PARENTS

10 NAME OF FATHER: Karl H. Stricker

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Charlotte Wuttrich

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

11 Informant: Mrs Lottie Heyl

(Address) 1514 N Wolfe

15 Filed APR 28 1929 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 28-1929

17 I HEREBY CERTIFY, That I attended deceased from April 23. 1929. to April 28. 1929.

that I last saw her alive on April 24. 1929

and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

(a) Erysipelas. Coxa,

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Albert Eisenberg M. D.

4/28. 1929 (Address) 2025 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem — DATE OF BURIAL: May 1 1929

20 UNDERTAKER: John Weick — ADDRESS: 2108 Aliceanna

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION necessary important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

45473 E

CERTIFICATE OF DEATH

90 E 45473

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1333 W. North Ave St. 14-30 Ward)

2-FULL NAME Florence Kramer

(a) RESIDENCE NO. 1333 W. North Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of No

6 DATE OF BIRTH (month, day, and year) Aug 15-1888

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	40	8	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework.
(b) General nature of industry, business, or establishment in which employed (or employer) None
(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER Alphus F Kramer

11 BIRTHPLACE OF FATHER (city or town) Pa.
(State or country)

12 MAIDEN NAME OF MOTHER Sarah J. Henly

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Daniel Kramer
(Address) Ruxton Md

15 Filed APR 29 1929 19 HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27th 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastric Insufficiency

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. C. Funk M. D.
(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	Apl 29 1929
20 UNDERTAKER	ADDRESS
Chesworth & Lenhart	417 se

Cor.—10-10-29—A Co.—100 Bks.

Catherine E. Broyles

HEALTH DEPARTMENT—CITY OF BALTIMORE

B 45474

CERTIFICATE OF DEATH

E 45474

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Johns Hopkins Hospital St. 13-52 Ward)

2-FULL NAME Catherine E. Broyles

(a) RESIDENCE NO. 3528 Hickory Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Howard Broyles

6 DATE OF BIRTH (month, day, and year) Sept 19/1908

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	20	7	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Mill Hand
(b) General nature of industry, business, or establishment in which employed (or employer) Mt. Vernon Mills
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Pa.

PARENTS

10 NAME OF FATHER Wm. McCarney

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Pa.

12 MAIDEN NAME OF MOTHER Anna Seitz

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Pa.

14 Informant Anthony Munzert
(Address) 3528 Hickory Ave

Filed APR 29 1929 HAMPSON JONES, M. D. Registrar

By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock-Hemorhage
(Ruptured left tubal pregnancy)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? At Hopkin Hospital

What test confirmed diagnosis?

(Signed) Jos. H. Bullen, M. D.

4/29/29 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's Evergreen	April 30 1929
20 UNDERTAKER	ADDRESS
Edmondson Bros	3410 Edmondson Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

45

E 45475

REGISTERED NO. E 45475

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1139 Poplar Grove ST. 16-68 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles W. Miller,

(a) RESIDENCE NO. 1139 Poplar Grove ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed, or Divorced~~, (write the word)
Male	White	Married

a If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Mamie C. Miller,

6 DATE OF BIRTH (month, day, and year) November 15. 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	51	5	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar Box Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Justus Miller,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Amelia Smith,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Mrs. Mamie C. Miller,

(Address) 1139 Poplar Grove St.

15 Filed APR 29 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) APR 27 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 3, 1928, to Apr 27, 1929, that I last saw him alive on Apr 27, 1929, and that death occurred, on the date stated above, at 8 p m.

The CAUSE OF DEATH* was as follows: Carcinoma of rectum

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Same (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Sept 13/28

Was there an autopsy? no

What test confirmed diagnosis? Lab

(Signed) Wm. Lester Miller, M. D.

4/29, 1929 (Address) 1319 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ Woodlawn

DATE OF BURIAL ... 19

ADDRESS

20 UNDERTAKER Geo H. Little

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

65-001

B 45476

CERTIFICATE OF DEATH

E 45476

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Hebrew Home for Aged 10 ST. WARD)

2—FULL NAME Solomon Glabstein

(a) RESIDENCE NO. 2100 E Balto Street ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or (Divorced) (write the word): Divorced

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Cant —

7 AGE: Years 69 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Dresser

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Blatt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Jack Lewis
(Address) 1439 E. Balto St

15 Filed APR 29 1929 H. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-29-29

17 I HEREBY CERTIFY, That I attended deceased from May, 1928, to April 28, 1929, that I last saw h alive on April 28, 1929 and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Lymphatic Leukemia

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

, 19 (Address) 1810 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale — DATE OF BURIAL: 4/29 1929

20 UNDERTAKER: Jack Lewis 1439 E Balto St — ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45477

45477

CERTIFICATE OF DEATH.

161-00

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bon Secours Hospital 2-7-56 ST., WARD

2-FULL NAME Baby Boy Vogel

(a) RESIDENCE NO. 710 Overnbury Ave
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced. (write the word): —

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 4-27-29

7 AGE — Years — Months — Days: 2 1/4 hours — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Bklyn. Ind.

PARENTS

10 NAME OF FATHER Dr. S. Z. Vogel

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York State

12 MAIDEN NAME OF MOTHER Dorothy D. Fox

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Hosp. record
(Address)

Filed APR 29 1929

S. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/27 1929

17 I HEREBY CERTIFY, That I attended deceased from 4/27, 1929, to 4/27, 1929, that I last saw him alive on 4/27, 1929, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Premature birth - Lived 2 1/4 hrs

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY
(Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Thos T Stacy Jr M. D.

, 19 (Address) Bon Secours Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bklyn Cemetery — DATE OF BURIAL: 4-29 1929

20 UNDERTAKER: Jack Lewis, — ADDRESS: 1431 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 45478

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 45478

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2503 McCulloh ST. 13-59 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lena Jones

(a) RESIDENCE NO. 2503 McCulloh ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F	C	W

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Jones

6 DATE OF BIRTH (month, day, and year) Oct 13, 1898

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
30	6	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Sol Fould

9 BIRTHPLACE (city or town) (State or country) Balto, Md

PARENTS

10 NAME OF FATHER Elisha Curry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Annie Nash

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Annie Howard

(Address) 1516 Jefferson St

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26 29

17 I HEREBY CERTIFY, That I attended deceased from Mar 24, 1929, to April 26, 1929, that I last saw h alive on April 26, 1929 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Cystitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Symptoms

(Signed) ..., M. D.

April 29 1929 (Address) 508 H St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cem	4-29 1929

20 UNDERTAKER Byron Wright ADDRESS 1218 McElderry St

mation should be carefully supplied. AGE should be stated [illegible] OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

2 of 1523

C. HAMPSON JONES M.D.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45479

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 45479

REGISTERED NO. 38

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 13 S. Penn ST. 4-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anderson Young

(a) RESIDENCE NO. 13 S. Penn ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Hannah Young

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	65	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) City Dept

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Hannah Young

(Address) 13 S. Penn St.

15 Filed APR 29 1929 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/26/29

17

I HEREBY CERTIFY, That I attended deceased from 4/4/29 to 4/26/29, that I last saw h[illegible] alive on 4/25/29, and that death occurred, on the date stated above, at 7.30 A m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation + Uremia

Duration ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Interstitial nephritis (probably Luetic) (duration) about yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical-Microscopical

(Signed) [illegible] M. D.

4/26/29, 19 (Address) 908 Sharp St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	April 29 19 29
20 UNDERTAKER	ADDRESS
C. W. Brown & Son	1058 W. Fayette St.

MATTER should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45480

CERTIFICATE OF DEATH

31

E 45480

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST. Path 51 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Mathews

(a) RESIDENCE NO. 1207 Depper ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, ~~Married, Widowed,~~ or ~~Divorced~~ (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE: Years 37 | Months | Days | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Printer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Fred Mathews

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Turner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Hospital Records
(Address)

Filed APR 29 1929, 19..... HAMILTON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-28-29

17 I HEREBY CERTIFY, That I attended deceased from 4-26-, 1929, to 4-27, 1929, that I last saw h.s.m. alive on 4-28-29, 19..... and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
alcoholism

(duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs....mos....ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Clinical Lab

(Signed) Henry C. Smith, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: 4 30 1929

20 UNDERTAKER: J. M. Cook — ADDRESS: 2174 Ford St.

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45481 E 45481

CERTIFICATE OF DEATH

100-09

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 26-35 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Julia Roman

(a) RESIDENCE NO. 55 S. Kresson ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records of

(Address) BALTIMORE CITY HOSPITALS

15 Filed APR 29 1929 Registrar. I. HARRISON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 6, 19 29 to April 27, 19 29

that I last saw her alive on April 27, 19 29

and that death occurred, on the date stated above, at 3:05 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Hospital

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam

(Signed) I. Harrison Jones M. D.

4-27, 19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn	4 29 1929
20 UNDERTAKER	ADDRESS
W. M. Cook	1217 E. Fort Ave

mation should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates. OF DEATH in plain terms, so that it may be properly classified.

Spec.—2-29-28—L. F. S.—500 Bks.

Dr Richard - 3201 N Paul St

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45482 — **CERTIFICATE OF DEATH** — 90 **E 45482**

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3125 N Calvert ST. 12-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Dora Louise Stainback

(a) RESIDENCE NO. 3125 N Calvert ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of John M Stainback

6 DATE OF BIRTH (month, day, and year) Nov. 10 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	5	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Henry B Goodmen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Julia A Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Miss C Lewis

(Address) 3125 N Calvert St

15 [illegible] 19

C. HAMPSON JONES, M. D.
Registrar

APR 25 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 27 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct — 1927 to April 27 1929

that I last saw her alive on April 27 1929

and that death occurred, on the date stated above, at 5.30 P. m.

The CAUSE OF DEATH* was as follows:

(1) Chronic Endocarditis

(duration) 1 yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) R. Richard M. D.

4/29 19 29 (Address) 320 N Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Ridge	4 30 19 29
UNDERTAKER D. Will Cook	ADDRESS 219 N Eutaw St

Before this certificate is filled out, the undertaker should be careful to see that the information is complete and correct. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Dr Beck 2300 St. Paul St

E 45483

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44 E 45483

1—PLACE OF DEATH

REGISTERED NO. 12-50

CITY OF BALTIMORE: (No. 2300 St Paul ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Richard H. Schurz.

(a) RESIDENCE NO. 2300 St Paul ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 15, 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	4	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Secretary

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Hopkins Lumber Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Charles F. Schurz.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Delia O'Loughlin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs O Schurz

(Address) 515 E 20th St

15 Date Received APR 20 1929 By C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 27, 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 14, 1929 to April 27, 1929 that I last saw him alive on April 27, 1929 and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Clinical diagnosis:
Carcinomatosis - (abdominal)

(duration) yrs. 5 mos. — ds.

CONTRIBUTORY (Secondary) Vasomotor Neurosis

(duration) yrs. mos. 1 ds. —

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes - Nature of growth

What test confirmed diagnosis? Still undetermined - Pathologic diagnosis to be made

(Signed) Harvey S Beck M. D.

Dated , 19 (Address) 22 St Paul and 22nd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 4/30 1929

UNDERTAKER H. M. Cook

ADDRESS 1217 Eutaw St

mation should be carefully supplied. Avoid words not in general use. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

JANOWSKI

E 45484 HEALTH DEPARTMENT—CITY OF BALTIMORE 31 E 45484

CERTIFICATE OF DEATH

1—PLACE OF DEATH REGISTERED NO.

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Konstanty Janowski

(a) RESIDENCE NO. 809 S. Ann ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1874

7 AGE — Years: 55 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER: Frank Janowski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Hospital Records
(Address)

15 Filed APR 29 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-27-29

17 I HEREBY CERTIFY, That I attended deceased from 2-4-, 1929, to 4-27, 1929, that I last saw h. alive on 4-27-, 1929 and that death occurred, on the date stated above, at 1:10 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lab & Clinical

(Signed) Henry C. Smith, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cemetery	April 30 1929.
20 UNDERTAKER	ADDRESS
George A. Weber	705 S. Ann St.

INFORMATION should be carefully supplied. ALL items should be answered. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Dr Mrs 538 E 22nd St

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45485

CERTIFICATE OF DEATH

131

E 45485

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 544 E 22nd ST. 9-46 (WARD)

2—FULL NAME Elaine Hummer

(a) RESIDENCE NO. 544 E 22nd ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Earl R Hummer

6 DATE OF BIRTH (month, day, and year): May 11, 1896

7 AGE — Years: 32 — Months: 1 — Days: 15 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer: At Home

9 BIRTHPLACE (city or town) (State or country): Cambridge Md

PARENTS

10 NAME OF FATHER: Wm Edgar

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Virginia Esor

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Earl R Hummer

(Address): 544 E 22nd St

15 [illegible] C. HAMPSON JONES, M. D. Registrar

APR 29 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 26 1929

17 I HEREBY CERTIFY, That I attended deceased from April 1 1929 to April 26 1929

that I last saw her alive on April 26 1929

and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Coronary Embolism

Arteriosclerosis

(duration) 15 min yrs. mos. ds.

CONTRIBUTORY (Secondary) Cystitis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Thomas J Hunter, M. D.

19 (Address) 502 E 22nd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cambridge, Md

DATE OF BURIAL: 4 30 1929

20 UNDERTAKER: W M Cook

ADDRESS: 219 Race St

mation should be carefully supplied. AGE should be stated EXACTLY. The PHYSICIAN'S CERTIFICATE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 45486 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 45486

1—PLACE OF DEATH

REGISTERED NO. 1307

CITY OF BALTIMORE? (No.) Baltimore City Hospitals (ST.) (W.B.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Gerusha Lucille Johnson

(a) RESIDENCE NO. 1536 W. Lexington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1909

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	20			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records

(Address)

APR 29 1929

G. JAMESON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 25, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 8, 1929, to April 25, 1929,

that I last saw her alive on April 25, 1929

and that death occurred, on the date stated above, at 11.30 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical and lab.

(Signed) Hugh C. Smith, M. D.

4-25-1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	April 30 1929
20 UNDERTAKER A. Jones	ADDRESS W. S. Gilm

mation should be carefully supplied. AGE should be stated EXACTLY. Where OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 45487

E 45487 F DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1962 Sponson St. ST. 25-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Wilhelmina Einolf

(a) RESIDENCE NO. 1962 Sponson St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of William P. Einolf

6 DATE OF BIRTH (month, day, and year) Dec. 4, 1859

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
69	4	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Flick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Otto W. Einolf

(Address) 1962 Sponson St.

15 Filed APR 29 1929 by HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 20, 1929, to April 26, 1929, that I last saw her alive on April 25, 1929 and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Hypertension - Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm. A. Stevens, M. D.

4/26, 1929 (Address) 1901 Guilford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	4/29/29
20 UNDERTAKER Harry T. Witzke, 53 W.	ADDRESS Lombard

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS, please state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45488

CERTIFICATE OF DEATH

75-001 E 45488

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2227 N Mount St. Ward) 19-2

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James E. Hopkins

(a) RESIDENCE NO. 2227 N. Mount St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: C

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Annie Hopkins

6 DATE OF BIRTH (month, day, and year): Dec 1. 1862

7 AGE: Years 66 Months 4 Days 26

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): 605

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Calvert County

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Beatrice Hicks

(Address) 2227 N. Mount St

15 Filed APR 29 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26 1929

17 I HEREBY CERTIFY, That I attended deceased from July 2 1928 to April 26 1929

that I last saw him alive on April 25 1929

and that death occurred, on the date stated above, at 2.45 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Arterio Sclerosis

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Paralysis

(duration) yrs. mos. 22 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Sign

(Signed) Jas E. Hooper M. D.

4-27-1929 (Address) 862 W. Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Auburn — Date of Burial: April 29 1929

20 UNDERTAKER: Joseph A Lively — ADDRESS: 409 N. Mount St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45489

CERTIFICATE OF DEATH

90

E 45489

REGISTERED NO.

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE: (No. [redacted] ST. 15-7 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Taylor

(a) RESIDENCE NO. 618 Collett ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Taylor

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Moses Taylor ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ? Unknown

12 MAIDEN NAME OF MOTHER Eliza ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records of
(Address) BALTIMORE CITY HOSPITALS

15 Filed APR 29 1929 19 THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 20, 19 29, to April 27, 19 29, that I last saw him alive on April 27, 19 29 and that death occurred, on the date stated above, at 5:30 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic, c
Insufficiency
55

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) Warren W. McClean, M. D.

4-27, 19 29 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Auburn — DATE OF BURIAL: May 1 1929

20 UNDERTAKER: Joseph A. Lively — ADDRESS: 708 N. Mount St

IMPORTANT. See instructions on back of certificates. Exact statement of OCCUPATION is very mation should be carefully supplied. AGE should be stated EXACTLY. If UNDER ONE YEAR, OR OF DEATH in plain terms, so that it may be properly classified.

Spec.—2-29-28—L. F. S.—500 Bks.

45490

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45490

CERTIFICATE OF DEATH

+ 47

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. University Hospital ST., 1 E. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Fannie Wade

(a) RESIDENCE NO. ~~University Hospital~~ ST., Glen Burnie Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 17 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Solomon Wade

6 DATE OF BIRTH (month, day, and year) Nov 11 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	36	5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework at

(b) General nature of industry, business, or establishment in which employed (or employer) home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Glenburnie Md

PARENTS

10 NAME OF FATHER Frank Wimmer

11 BIRTHPLACE OF FATHER (city or town) Bavaria (State or country) Germany

12 MAIDEN NAME OF MOTHER Fannie Vogelmeier

13 BIRTHPLACE OF MOTHER (city or town) Bavaria (State or country) Germany

14 Informant Mr Solomon Wade

(Address) 3 Ave Dist Glenburnie Md

15 Filed APR 29 1929 LAMPSON M. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26, 1929

17

I HEREBY CERTIFY, That I attended deceased from April 7, 1929, to April 26, 1929, that I last saw h[illegible] alive on April 26, 1929 and that death occurred, on the date stated above, at 4:00 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of left breast.

(duration) yrs. 4 mos. — ds.

CONTRIBUTORY (Secondary) Cachexia.

(duration) yrs. 4 mos. — ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of April 9, 1929

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) L. C. Lumpkin, M. D.

4/26, 1929 (Address) Municipality Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	April 30 1929
20 UNDERTAKER John F. Denny	ADDRESS 715 Light St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 45491 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16-22-90 E 45491

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 803 Brice Street ST. 16-22 WARD)

2-FULL NAME Thomas E. Snyder

(a) **RESIDENCE** No. 803 Brice Street ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of- Mary T. Snyder

6 DATE OF BIRTH (month, day, and year) 12/22/1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	56	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shipping Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas E. Snyder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Reuchling

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary T. Snyder (Address) 803 Brice Street

15 Filed APR 29 1929 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 1929.

17 I HEREBY CERTIFY, That I attended deceased from April 8, 1929, to Apr 27, 1929, that I last saw him alive on April 26, 1929 and that death occurred, on the date stated above, at 11.50 p. m.

The CAUSE OF DEATH* was as follows:

Myocarditis -

(duration) yrs. mos 20 ds.

CONTRIBUTORY (Secondary) Cardiac decompensation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ✓ Date of

Was there an autopsy? ✓

What test confirmed diagnosis? ✓

(Signed) George Abner Bowden, M. D.

4/29/29 (Address) 1517 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: 5/1 1929

20 UNDERTAKER: George J. Ruth — ADDRESS: 1735 HARFORD AV

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 45492 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 45492

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2009 Robb Street ST. 9-46 WARD)

2-FULL NAME Elizabeth Norman

(a) RESIDENCE NO. 2009 Robb Street ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred ~~Life~~ 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
~~Female~~	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Henry A. Norman

6 DATE OF BIRTH (month, day, and year) 6/28/1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	10.		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Liberty Md.

PARENTS

10 NAME OF FATHER Samuel Eppley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER R. Bixler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Edith R. McComas

(Address) 2009 Robb Street

15 Filed APR 29 1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-28-1929

17 I HEREBY CERTIFY, That I attended deceased from April 25 , 1929 , to April 28 , 1929 , that I last saw her alive on April 27 , 1929 and that death occurred, on the date stated above, at 10:30 a m

The CAUSE OF DEATH* was as follows:

Acute Cardiac dilatation

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) ~~2 months~~ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James E Ashenhurst M. D.

4-29-1929 (Address) 4012 Park Heights

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Union Bridge Md

DATE OF BURIAL 5/2 1929

20 UNDERTAKER George J Ruth

ADDRESS 1755 HARFORD AV.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45493 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129

E 45493

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. [redacted] ST. 5-17 WARD)

2—FULL NAME Oscar Carrick

(a) RESIDENCE NO. 1912 Oliver ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknonw

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Meat cutter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Ben Carrick

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Babb

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maine

14 Informant Records of

(Address) BALTIMORE CITY HOSPITALS

Filed APR 29 1929 WILLIAM H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28, 1929

17

I HEREBY CERTIFY, That I attended deceased from December 28, 19 28 to April 28, 19 29

that I last saw h im alive on April 28, 19 29

and that death occurred, on the date stated above, at 12:45 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage, ot

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Interstitial Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Laboratory

(Signed) R. H. Jack, M. D.

, 19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery — DATE OF BURIAL 5/1 1929

UNDERTAKER George J. Ruth — ADDRESS 1750 Harford Ave

N. B.—WRITE PLAINLY, WITH CONSIDERABLE DETAIL. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45494

CERTIFICATE OF DEATH.

90 ✓

REGISTERED NO. E 45494

1-PLACE OF DEATH

City of BALTIMORE, (No.) 2602 Guilford St. 12-50 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John R. Barnard

(a) RESIDENCE NO. 2602 Guilford St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, Widowed, or divorced HUSBAND of (or) WIFE of: Margaret D. Barnard

6 DATE OF BIRTH (month, day, and year): 4 | 6 | 1855

7 AGE: Years 74 Months 0 Days 20 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Bricklayer

(b) General nature of industry, business, or establishment in which employed (or employer): Oil

(c) Name of employer

9 BIRTHPLACE (city or town): Md

(State or country)

PARENTS

10 NAME OF FATHER: Richard Barnard

11 BIRTHPLACE OF FATHER (city or town): Md

(State or country)

12 MAIDEN NAME OF MOTHER: Mary Trumpower

13 BIRTHPLACE OF MOTHER (city or town): Md

(State or country)

14 Informant: Margaret Barnard

(Address) 2602 Guilford ave

15 Filed ..... 19 .....

APR 29 1926 C. HAMPTON JONES, M. D. Registrar

Per .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/26 1926

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Disease Heart

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible] M. D.

(Coroner)

4/26 1926 (Address) 3632 Roland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

IS LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — Date of Burial: 4/29 19 26

20 UNDERTAKER: George J. Ruth — ADDRESS: 1736 Linford Ave

NOTE.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45495

CERTIFICATE OF DEATH

E 45495

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE, (No.) Southern Hospital (ST.) 1352 (WARD)

2—FULL NAME Thomas F Cole Sr

(a) RESIDENCE NO. 3430 Chestnut Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, ~~or Divorced~~, (write the word)
Male	white	widowed

6 If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mary Ann Cole

6 DATE OF BIRTH (month, day, and year) March 4, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	1	23	14

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waterman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Thomas F Cole

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Thomas F Cole Jr

(Address) 3430 Chestnut Ave

15 Filed APR 29 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28, 1929

17

I HEREBY CERTIFY, That I attended deceased from about June, 1927, to April 28, 1929, that I last saw h[illegible] alive on April 26, 1929 and that death occurred, on the date stated above, at 8.00 a. m.

The CAUSE OF DEATH* was as follows:

Cardio-Vascular Disease

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? [illegible]

(Signed) [illegible], M. D.

Apr 29 1929 (Address) 1716 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	May 1st 1929
20 UNDERTAKER	ADDRESS
Robt L Turner Inc	1442 N Broadway

N. B.—WHITE PAPER, WITH BLACK INK should be used. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 45496 HEALTH DEPARTMENT—CITY OF BALTIMORE 162 **E 45496**

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 871 W. Fairmount Ave 18-26 (Ward)

2-FULL NAME Junior Lockhardt

(a) RESIDENCE NO. 871 W. Fairmount St. Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Negro	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 8 / 29

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
			19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Sinclair Lockhardt

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Ella Smith

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Sinclair Lockhardt
(Address) 871 W. Fairmount Ave

APR 29 1929 HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Congenital Atelectasis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Eugene Zellert, M. D.

4/29 1929 (Address) 739 Eastern ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury City	April 29 1929
20 UNDERTAKER	ADDRESS
Leonard Whalen	698 Spring

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

45497 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. **E 45497**

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 3704 Woodhaven a ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Levin Bailey

(a) RESIDENCE. No. 3704 Woodhaven ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 87 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 9 - 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	5	18.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Builder

(b) General nature of Industry, business, or establishment in which employed (or employer) 016

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Church Creek Md

PARENTS

10 NAME OF FATHER William A Bailey

11 BIRTHPLACE OF FATHER (city or town) (State or country) York Pa

12 MAIDEN NAME OF MOTHER Nancy A Richardson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cambridge Md

14 Informant Mrs Levin Baily
(Address) 3704 Woodhaven

15 Filed , 19 C. HAMILTON JONES, M. D.
Registrar
Per

APR 29 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 1929

17 I HEREBY CERTIFY, That I attended deceased from March 16, 1929, to April 27, 1929, that I last saw him alive on April 26th, 1929, and that death occurred, on the date stated above, at 5:30 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 1 mos. 13 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John Wolff, M. D.

, 19 (Address) 1043 N. Bailor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	Ap 29 1929
20 UNDERTAKER George J Smith	ADDRESS 1532 Hollins

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45498 — CERTIFICATE OF DEATH — 117 — E 45498

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Josephs Hosp (St.) (WARD) 23-31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Mulligan

(a) RESIDENCE NO. 6 West Oston ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Jos F. Mulligan

6 DATE OF BIRTH (month, day, and year) Sept 29 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	47	6	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Baltimore

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Robt. Forrester

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Margaret McCourtney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Jos. F Mulligan

(Address) 6 W. Oston st.

15 Filed APR 29 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 27-1929

17 I HEREBY CERTIFY, That I attended deceased from Apr. 25 1929 to Apr. 27 1929

that I last saw h[illegible] alive on Apr. 27 1929

and that death occurred, on the date stated above, at 10 30 a.m.

The CAUSE OF DEATH* was as follows:

Appendicitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Apr. 25-29

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) H. Hampton M. D.

4-25. 1929 (Address) St Josephs Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	Apr 30 1929
20 UNDERTAKER	ADDRESS
Margaret G. Flynn	1422 Light

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

223881

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45499 × 90 E 45499

CERTIFICATE OF DEATH

1—PLACE OF DEATH JOHNS HOPKINS HOSPITAL REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 9-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Daniel P. Blair

(a) RESIDENCE NO. 111 N. Potomic St Hagerstown Md ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 28 ds. How long in U. S., If foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work R.R. Conductor

(b) General nature of industry, business, or establishment in which employed (or employer) OP

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Philip D.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Sarah Ford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed APR 29 1929 C. HAMPSON JONES, M. D. Registrar

by

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28-1929

17 I HEREBY CERTIFY, That I attended deceased from March 30 1929, to April 28, 1929, that I last saw h[illegible] alive on April 28, 1929 and that death occurred, on the date stated above, at 10 55 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

(duration) — yrs. 8 mos. — ds.

CONTRIBUTORY (Secondary) Pulmonary Infarction, Coronary Thrombosis (duration) — yrs. — mos. 13 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Harold Weinstein, M. D.

4-29 1929 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hagerstown Md	April 30 1929
20 UNDERTAKER	ADDRESS
Scott & Minnick	Hagerstown Md

-29—A Co.—100 Blks.

Owings

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-002

E 45500

CERTIFICATE OF DEATH

E 45500

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

y of Baltimore: (No. 1400 N. Washington St St., 8-17 Ward)

2-FULL NAME "Baby" Owings

(a) RESIDENCE NO. 1400 N. Washington St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 25/29

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
		2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Charles Owings

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Helen Baker

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto., Md.

14 Informant Charles Owings
(Address) 1400 N. Washington St

Filed APR 29 1929 HAMPSON JONES, M. D. Registrar

By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 27/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Prematurity (5 mon. gestation)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Probable Cerebral Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Jones, M. D.

4/29/ 19 (Address) 503 E. North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Lem	April 29th 29
20 UNDERTAKER	ADDRESS
Leo S. Cook	1723 Pat[illegible]

Cure

N. B.—W... PLAIN... tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS OF DEATH in plain terms, so that it may be properly classified. Exact statement of C... important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45501 21 E 45501

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Sydenham Hospital 1-3 ST., WARD)

2—FULL NAME Zelick Bender

(a) RESIDENCE NO. 2227 E. Pratt St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., If foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Etta Chesa Bender

6 DATE OF BIRTH (month, day, and year) Unk

7 AGE	Years	Months	Days	If LESS than 1 day, ..hrs. or ..min.
	62	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Mendel Bender

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Chippa Bebader

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Harry Bender

(Address) 1625 E. Baltimore St

15 Date APR 29 1929 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 27, 1929, to April 28, 1929, that I last saw him alive on April 28, 1929, and that death occurred, on the date stated above, at 4.50 a m.

The CAUSE OF DEATH* was as follows:

Erysipelas faciallis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Myocardial Decompensation

(duration) yrs. mos. ? ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Myron G. Zell, M. D.

4/28, 1929 (Address) Sydenham Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Rest

DATE OF BURIAL 4/29 1929

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E. Balto St

...ed EXACTLY as it appears on the back of certificates. Exac... statement of OCCUPATION is very ...NS should be ...SE ...mate ...OF D... ...importan...

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 45502 — BALTIMORE CITY HOSPITALS — 49 — E 45502

1—PLACE OF DEATH [redacted] 2-4 — REGISTERED NO.

CITY OF BALTIMORE: (No. ____ ST. ____ WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Kuhn

(a) RESIDENCE NO. 1600 Aliceanna ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Augusta Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Kuhn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Records of

(Address) [redacted]

15 Date received APR 29 1928 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26, 1928

17 I HEREBY CERTIFY, That I attended deceased from April 17, 1928 to April 26, 1928

that I last saw him alive on April 26, 1928

and that death occurred, on the date stated above, at 6:05 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate

several months (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Surgical & autopsy

(Signed) R. H. Stock, M. D.

, 19 (Address) [redacted]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Pauls Cemetery	4/30/1928
20 UNDERTAKER	ADDRESS
John J. Connolly	Essex

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 45503 32 E 45503

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp. St. 86-41 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles E. Lecompte, Jr.

(a) RESIDENCE NO. 4209 E. Woodlea Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct. 8. 1928

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	—	6	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Chas. E. Lecompte

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Evelyn M. Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto, Md

14 Informant Evelyn M. LeCompte

(Address) 4209 Woodlea ave

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

APR 29 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/28/29.

17 I HEREBY CERTIFY, That I attended deceased from 4/25/29, 19..., to 4/28/29, 19..., that I last saw him alive on 4/28/29, 19..., and that death occurred, on the date stated above, at 9.30 a.m.

The CAUSE OF DEATH* was as follows:

I. B. meningitis.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical + Lab.

(Signed) C. C. Zeller, M. D.

, 19 (Address) St Josephs

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oakland Cemetery — DATE OF BURIAL April 30 1929

20 UNDERTAKER George W. Zinkler — ADDRESS 1737 E. Eager St.

IMPORTANT—WRITE WITH PENCIL OR PEN AND INDELIBLE INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45504

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45504

CERTIFICATE OF DEATH

1—PLACE OF DEATH Johns Hopkins Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret Thompson

(a) RESIDENCE NO. Havre de Grace ST., Md. WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	child

a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 7/27/21

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	7	9	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. J.

PARENTS

10 NAME OF FATHER Irvin

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. J.

12 MAIDEN NAME OF MOTHER Elizabeth Hamlin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. J.

14 Informant Mrs. Irvin Thompson

(Address) Havre de Grace, Md.

15 Date APR 29 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29-1929

17 I HEREBY CERTIFY, That I attended deceased from April 26, 1929, to April 29, 1929, that I last saw him alive on April 24, 1929 and that death occurred, on the date stated above, at — m.

The CAUSE OF DEATH* was as follows:

Tuberculous meningitis

3 wks. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Spinal fluid exam.

(Signed) L. C. Godwin, M. D.

APR 30, 1929 (Address) J. H. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Angel Hill Cem.

DATE OF BURIAL May 1, 1929

20 UNDERTAKER

ADDRESS Geo. A. Wiseman & Sons 1922 Eutaw Pl.

APR 29 1929

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-[illegible]—L. P. S.—500 Blks.

E 45505

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-081

E 45505

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1310 E. Lafayette Ave ST. 8-45 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Grace L. Barton

(a) RESIDENCE NO. 3013 Erdman Ave. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Seth W. Barton

6 DATE OF BIRTH (month, day, and year): July 30-1882

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
46	8	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Henry Ewalt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Mary E. McElwee

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Seth W. Barton
(Address) 3013 Erdman ave.

15 Filed APR 29 19[illegible] HAMPSON JONES, M. D.
Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 28-29

17 I HEREBY CERTIFY, That I attended deceased from April 26, 1929, to April 28, 1929, that I last saw her alive on April 28, 1929 and that death occurred, on the date stated above, at 945 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): Pneumonia - Lobar

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wallis W. White M. D.

4-29, 1929 (Address) 2800 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem.	May 1 1929
20 UNDERTAKER	**ADDRESS**
Wm. E. Black	927 N. Broadway

IMPORTANT: THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Rks.

E 45506

HEALTH DEPARTMENT—CITY OF BALTIMORE E 45506

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2133 McHenry St. St.) (7-10-69 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ottillie Glatthaar

(a) RESIDENCE. No. 2133 McHenry St., ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 4 mos. ds. How long in U. S., if of foreign birth? 66 yrs ~ mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Peter Glatthaar

6 DATE OF BIRTH (month, day, and year) Dec. 27 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75			
	76	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Roemer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Christian G. Glatthaar 2133 McHenry St.,

15 Filed C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/27 1929

17

I HEREBY CERTIFY, That I attended deceased from April 24, 1929, to April 27, 1929, that I last saw her alive on April 27, 1929 and that death occurred, on the date stated above, at 11:15 P. m.

The CAUSE OF DEATH* was as follows:

Uraemia Coma
Pulmonary Oedema
Chronic Interstitial Nephritis (duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

4/29, 1929 (Address) 1729 N. [illegible] St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem.

DATE OF BURIAL April 30. 1929

20 UNDERTAKER C. W. Dill

ADDRESS 3109 Frederick Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PR 291929

Spec.—1-10-21—M&T—1500 Bks.

E 45507 HEALTH DEPARTMENT—CITY OF BALTIMORE E 45507

CERTIFICATE OF DEATH.

1-PLACE OF DEATH U.S. Marine Hospital, Baltimore, Md.

CITY OF BALTIMORE: (No. ..... ST., 17-51 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edgar E. Jones

(a) RESIDENCE NO. Stone Mountain, Ga. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~~29~~ yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	wh te	widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 29, 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	11	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Stone Mountain
(State or country) Georgia

PARENTS

10 NAME OF FATHER John H. Jones

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Georgia

12 MAIDEN NAME OF MOTHER Martha Anna Wade

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Georgia

14 Informant Records, U.S. Marine Hospital
(Address) Baltimore, Maryland

15 Filed C. HAMPSON JONES, M. D.
Per ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28 19 29

17 I HEREBY CERTIFY, That I attended deceased from JAnuary 30, 19 29, to April 28, 19 29,

that I last saw h im alive on April 28, 19 29,

and that death occurred, on the date stated above, at 6:45 p. m.

The CAUSE OF DEATH* was as follows:

Valvular heart disease, combined lesions. aortic and mitral

unknown
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Laboratory & clinical findings

(Signed) Ralph E. Porter, M. D.

4/29, 19 29 (Address) U.S. Marine Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL U.S. National Cem

DATE OF BURIAL 5/1st 1929

20 UNDERTAKER Robert Brooks Edson

ADDRESS Baltimore Hollins St

APR 29 1929

W. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be given in YEARS. PHYSICIANS should fill in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 45508 HEALTH DEPARTMENT—CITY OF BALTIMORE **E 45508**

CERTIFICATE OF DEATH.

V. 90

1-PLACE OF DEATH Franklin Square Hospital.

CITY OF BALTIMORE: (No. Calhoun & Fayette ST. 15-16 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mathew Pappacostas

(a) RESIDENCE No. 936 W. Lexington ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
about	45.	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor. 10

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Greece

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Robert Brooks & Son

(Address) 11 Calhoun St

15 Filed APR 29 1929 C. HAMPSON JONES, M. D. Registrar

Per WRS

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27 1929

17

I HEREBY CERTIFY, That I attended deceased from Feb 8 1929 to April 27 1929, that I last saw hemalive on April 27 1929, and that death occurred, on the date stated above, at 7:45 P m.

The CAUSE OF DEATH* was as follows:

Generalized arterio-sclerosis

Aortic Stenosis.

Bilateral pleural effusion ?

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Elizabeth B. Sherman, M. D.

4/27/1929 (Address) Franklin Sq. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem

DATE OF BURIAL 4/30 1929

20 UNDERTAKER Robert Brooks & Son

ADDRESS Calhoun Hollins

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

WARNING—RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

E 45509 HEALTH DEPARTMENT—CITY OF BALTIMORE E 45509

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Sinai Hospital

REGISTERED NO. 90

CITY OF BALTIMORE: (No. Monument & Rutland ST. 4-25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Solomon Friedman

(a) RESIDENCE NO. New Howard Hotel ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec. 1, 1864

7 AGE — Years: 64 — Months: 4 — Days: 27 — If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto, Md.

PARENTS

10 NAME OF FATHER: Phinka Friedmann

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Caroline Prager

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mr. H. Friedmann

(Address): Emerson & Gay Sts.

15 Filed ....., 19.... Registrar C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4-28 1929

17 I HEREBY CERTIFY, That I attended deceased from 4-18, 1929, to 4-28, 1929, that I last saw him alive on 4-28, 1929, and that death occurred, on the date stated above, at 3:15 a m.

The CAUSE OF DEATH* was as follows:

Myocardial Insuff & Failure

Arteriosclerosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Bernard J. Cohen M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship Cem.

DATE OF BURIAL: 4/30/1929

20 UNDERTAKER: Reid Sondheim

ADDRESS: 115 Lombard St

Royal Cem

WARNING—RESERVED FOR BINDING

P. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PR 29 1929

Spec.—2-29-28—L. F. S.—600 Bks.

E 45610 HEALTH DEPARTMENT—CITY OF BALTIMORE 90E 48510

CERTIFICATE OF DEATH

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 815 Newington Ave. ST. 13-54 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Bertha Schapiro

(a) RESIDENCE NO. 815 Newington Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob Schapiro

6 DATE OF BIRTH (month, day, and year) Jany. 1st. 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	3	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Leto - Europe

PARENTS

10 NAME OF FATHER Yedessa Seeman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Gerald Cook

(Address) 815 Newington Ave

15 Filed APR 29 1929, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29th. 1929

17 I HEREBY CERTIFY, That I attended deceased from April 14, 1929, to April 29, 1929, that I last saw h alive on April 28, 1929, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Broncho - Pneumonia

about 2 wks.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchial Asthma & myocarditis (duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Theodore H. Morrison M. D.

, 19 (Address) 1013 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Hebrew Cem.	4/30/ 1929
20 UNDERTAKER Ward Sondheim	ADDRESS 118-20 W Mt Royal Ave

Spec.—1-10-21—M&T—1500 Blks.

E 45511 HEALTH DEPARTMENT—CITY OF BALTIMORE E 45511

CERTIFICATE OF DEATH.

REGISTERED NO. 129

1-PLACE OF DEATH Franklin Square Hospital

CITY OF BALTIMORE: (No. Calhoun & Fayette ST. 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sophie Hill

(a) RESIDENCE No. 1056 W. Fayette ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	black	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	34	5	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant James Bailey (Address) 1056 W Fayette St

15 Filed [illegible] C. HAMPSON JONES, M. D. Registrar

Per [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28 1929

17 I HEREBY CERTIFY, That I attended deceased from April 26, 1929, to April 28, 1929, that I last saw h[illegible] alive on April 27, 1929, and that death occurred, on the date stated above, at 3:15 A. m.

The CAUSE OF DEATH* was as follows:

Hypertensive cardio vascular renal disease, chronic nephritis, Myocardial, Chronic

(duration) yrs. ? mos ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Salvarsan tests

(Signed) Elizabeth B Sherman, M. D.

4/28, 1929 (Address) Franklin Sq. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Maassanetta Va.

DATE OF BURIAL 4-30 1929

20 UNDERTAKER Vennet Everhart

ADDRESS 916 Va ave

N) B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45512

CERTIFICATE OF DEATH

57

E 45512

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 111 N Streeper ST., 6-11 WARD)

2—FULL NAME Elizabeth Reinhardt

(a) RESIDENCE NO. 111 N. Streeper ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married, Widowed,~~ or Divorced, (write the word): Widowed

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: the late George Reinhardt

6 DATE OF BIRTH (month, day, and year): Sept 15th 1864

7 AGE — Years: 64 | Months: 7 | Days: 13 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Augusta Klaf
(Address) 111 N Streeper St.

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 28/29

17 I HEREBY CERTIFY, That I attended deceased from April 26, 1929, to April 28, 1929, that I last saw h~~er~~ alive on 4/28/ ——, 1929 and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Diabetes mellitus

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Acute Myocarditis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Hubert Artigan M. D.

, 19 (Address) 2942 E. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem — DATE OF BURIAL: May 1 1929

20 UNDERTAKER: Jas C. Fuller & Son — ADDRESS: 2364 Jefferson

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

PR 29 1929

Spec.—1-12-23—M&T—500 Bks.

E 45513

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

158

E 45513

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital St. 27-72 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Wm Sindall

(a) RESIDENCE NO. 6000 W. Parkemont Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Susie Sindall

6 DATE OF BIRTH (month, day, and year) May 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real Estate

(b) General nature of industry, business, or establishment in which employed (or employer) Salesman

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Edwin Sindall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mr Wm Sindall

(Address) 6000 W. Parkemont Ave

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-29 1929

17 I HEREBY CERTIFY, That I attended deceased from 3-24, 1929, to 4-29, 1929

that I last saw him alive on April 29, 1929,

and that death occurred, on the date stated ~~above~~, at 2 A.M m.

The CAUSE OF DEATH* was as follows:

Asphyxia, obliteration of lungs

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Myositis ossificans

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of Some time prior to admission

Was there an autopsy? yes

What test confirmed diagnosis? Microscopic

(Signed) [illegible], M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL (Parkwood)

DATE OF BURIAL May 2 1929

20 UNDERTAKER [illegible]

ADDRESS [illegible]

PR 29 1929

C. HAMPSON JONES, M. D.
Registrar

By [illegible]

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45514 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

76 E 45514

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mt Hope Retreat ST., 28-63 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Phillip McLoughlin

(a) RESIDENCE NO. 311 N 52nd St Phila. Pa. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 1 mos. — ds. — How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A. McLoughlin

6 DATE OF BIRTH (month, day, and year) Aug 18 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	7	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Druggist

(b) General nature of industry, business, or establishment in which employed (or employer) Drugs

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) York Pa

PARENTS

10 NAME OF FATHER Mark McLoughlin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Bradley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pittsburgh Pa

14 Informant Mt Hope Retreats

(Address) Mt Hope Retreat

15 Filed APR 29 1929 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 29 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1924, to Apr 29, 1929, that I last saw h[illegible] alive on Apr 29, 1929 and that death occurred, on the date stated above, at 1.25 P m.

The CAUSE OF DEATH* was as follows:

Paresis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dementia

(duration) 5 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? None Date of —

Was there an autopsy? No

What test confirmed diagnosis? Wassermann

(Signed) Milton P. Idell M. D.

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL York Pa — DATE OF BURIAL 4 29 1929

20 UNDERTAKER C. Wilbur York — ADDRESS 127 E Philada

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 45515 HEALTH DEPARTMENT—CITY OF BALTIMORE **E 45515**

CERTIFICATE OF DEATH.

REGISTERED NO. 135

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bon Secours Hospital ST. W-27 WARD)

2-FULL NAME Edward M. Kabae

(a) RESIDENCE NO. 218 Clarendon Ave - Pikesville ST. Md. WARD

(Usual place of abode)

Length of residence in city or town where death occurred ~~65~~ yrs. mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Joanna Lynch Kabae

6 DATE OF BIRTH (month, day, and year) 3-29-1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	65	11	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford Co Md

PARENTS

10 NAME OF FATHER Michael Kabae.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Margaret Howeland.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Edward M Kabae. (Address) 218 Clarendon Ave Pikesville Md

15 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/27 1929

17 I HEREBY CERTIFY, That I attended deceased from April 14 1929 to April 27, 1929.

that I last saw him alive on 4/27 1929.

and that death occurred, on the date stated above, at 7:40 a m.

The CAUSE OF DEATH* was as follows:

(1) Paralytic ileus

(2) Hypostatic pneumonia

(duration) yrs. mos. (1) 7 (2) 1½ ds.

CONTRIBUTORY (Secondary) Benign hypertrophy of prostate (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 4/14/29

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Theo. E. Stacy, Jr. M. D.

(Address) Bon Secours Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery — DATE OF BURIAL 4-30-29

20 UNDERTAKER M. Fahey & Sons — ADDRESS 1827 N. North Ave.

FR 29 1929

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

E 45516

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45516

CERTIFICATE OF DEATH

REGISTERED NO. 129

1-PLACE OF DEATH Jenkins Memorial Hospital

City of BALTIMORE: (No. 5000 Caton Ave. St. 25-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Evelyn Zeleski

(a) RESIDENCE NO. Jenkins Memorial St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. 7 mos. 1 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept. 28, 1912

7 AGE: Years 16 Months 7 Days 1

IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Unknown.

12 MAIDEN NAME OF MOTHER Mary Miller.

13 BIRTHPLACE OF MOTHER (City or town)

(State or country) Md.

14 Informant Jenkins Memorial Hospital

(Address) 5000 Caton Avenue

C. HAMPSON JONES, Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29 19 29

17 I HEREBY CERTIFY, That I attended deceased from 8-1, 19 29, to 4/29, 19 29.

that I last saw h[illegible] alive on 4/28, 19 29.

and that death occurred, on the date stated above, at 2:10 a m.

The CAUSE OF DEATH* was as follows:

Endocarditis Rheumatic Chronic

Myocarditis Chronic

Chronic Interstitial Nephritis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Endocarditis Chronic Rheumatic

(duration) 4 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Physical.

(Signed) R. H. Jones M. D.

, 19 (Address) Diagnosis Post Mortem

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

Date of Burial: 4-30-29

20 UNDERTAKER: M. Fasig Sons

ADDRESS: 15 W North Ave

APR 29 1929

REGISTRAR'S REQUEST FOR BINDING

NOTICE TO PHYSICIANS AND UNDERTAKERS.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 45517 HEALTH DEPARTMENT—CITY OF BALTIMORE E 45517

CERTIFICATE OF DEATH.

REGISTERED NO. 1627

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hosp. ST., (or) WARD)

2-FULL NAME Baby Gardner

(a) RESIDENCE No. 1805-W. Saratoga St. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Baby.

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 4-28-29.

7 AGE	Years	Months	Days	If LESS than 1 day, 3 hrs. or min.
	few hours	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) St. Agnes Hosp. Balto. Md.

PARENTS

10 NAME OF FATHER Paul L. Gardner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mary Elma Rumney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St Marys County Md.

14 Informant Paul L. Gardner

(Address) 1805 W Saratoga St

15 Dated PR 28 1929, 19

C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-28-29

17

I HEREBY CERTIFY, That I attended deceased from 4-28, 1929, to 4-28, 1929, that I last saw him alive on 4-28, 1929, and that death occurred, on the date stated above, at 7^00 P. m.

The CAUSE OF DEATH* was as follows:

Premature gestation and Pyonephrosis in mother.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pyonephrosis in mother.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 4-28-29.

Was there an autopsy? No

What test confirmed diagnosis? Cesarean section of mother.

(Signed) [illegible], M. D.

4-29, 1929 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Md

DATE OF BURIAL 4/30/29

20 UNDERTAKER Harry A Wilzbe

ADDRESS 1831 O Fleetwood

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45518 HEALTH DEPARTMENT—CITY OF BALTIMORE **E 45518**

101-08

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1641 Fleet ST. 2-4 WARD) REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME CHARLES H. PICKELBERG

(a) RESIDENCE NO. 1641 Fleet ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) November 14, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) New Jersey

PARENTS

10 NAME OF FATHER Frederick Pickelberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Wilhelmina Treste

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Miss Emma Drager (Neice)

(Address) 1641 Fleet St.

15 Filed ....., 19 .....

C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 20, 1929, to April 29, 1929

that I last saw him alive on April 29, 1929

and that death occurred, on the date stated above, at 9.40 a. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) ..... yrs. ..... mos. 9 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) John Wade, M. D.

, 19 (Address) 118 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Angel Hill Cemetery Havre de Grace, Md.

DATE OF BURIAL May 1 1929

20 UNDERTAKER Henry Sander & Sons. Inc.

ADDRESS BALTIMORE ST. & BROADWAY.

PR 29 1929

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45519

CERTIFICATE OF DEATH

REGISTERED NO. E 45519

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Baltimore City Hospitals ST., (E. B.) WARD)

2—FULL NAME Lelia Wilson

(a) RESIDENCE NO. 1522 E. Pratt st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records

(Address)

15 Date APR 30 1929 HAMPSON JONES, M. D. Registrar

Reg. 3028

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 26, 1929

17

I HEREBY CERTIFY, That I attended deceased from April 25, 1929, to April 26, 1929,

that I last saw her alive on April 26, 1929

and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Expectoration

(Signed) Henry C. Smith, M. D.

4-26, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS APR 29 1929

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Mischuke

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45520

E 45520 CERTIFICATE OF DEATH 31

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST. 22-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Victor Miscmik

(a) RESIDENCE NO. 214 W. Camden st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records

(Address) UNIVERSITY OF MARYLAND

15 Date Received APR 30 1929 16 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23, 1929

17

I HEREBY CERTIFY, That I attended deceased from April 15, 1929, to April 23, 1929, that I last saw him alive on April 23, 1929, and that death occurred, on the date stated above, at 4.50 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Uncertain yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Clinical Dx

What test confirmed diagnosis?

(Signed) Henry Smith, M. D.

4-23-, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

APR 29 1929

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 45521 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 E 45521

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hospital (Street) 16-22 (WARD)

2-FULL NAME Adelia Brooks

(a) RESIDENCE No. 1014 N Carey ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years: — Months: 6 6/30 — Days: 7 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balt. Md.

PARENTS

10 NAME OF FATHER: William Brooks

11 BIRTHPLACE OF FATHER (city or town) (State or country): ? Maryland

12 MAIDEN NAME OF MOTHER: Ada Haigh

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Calvert Co. Maryland

14 Informant (Address): Mother

15 Filed APR 30 1929 Registrar

16 Certified, Received

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 26 1929

17 I HEREBY CERTIFY, That I attended deceased from Apr 24, 1929, to Apr 26, 1929, that I last saw h[illegible] alive on Apr 26, 1929, and that death occurred, on the date stated above, at 5:20 A m.

The CAUSE OF DEATH* was as follows:

Cong. Syphilis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Marasmus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) J. F. Jackson M.D.

4/29/29 (Address) Coonamington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER: [illegible] HAMPSON JONES, M. D.

ADDRESS: Commissioner Health

APR 29 1929

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45522

CERTIFICATE OF DEATH

74-001

E 45522

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1720 Longwood St. 15-61 Ward)

2-FULL NAME Anna M. Seiffel

(a) RESIDENCE NO. 1720 Longwood St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John M. Seiffel

6 DATE OF BIRTH (month, day, and year) May 9-1881

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	48	1	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER John Gormley

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Lucy Henry.

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant John M. Seiffel
(Address) 1720 Longwood.

Filed APR 30 1929 HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) April 27th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(Apoplexy) (duration) ..... yrs. Sudden

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) Fred Seitz M. D.
Coroner.
(Address) April 27-1929

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Hill Cemetery	April 30th 1929
20 UNDERTAKER	ADDRESS
F. B. Wilhelm	1850 N. Bucknell

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45523 — CERTIFICATE OF DEATH — 129 — **E 45523**

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2113 Mc Henry St. 20-69 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lena Schwanetzke

(a) RESIDENCE NO. 2113 Mc Henry ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth 50 yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

6 DATE OF BIRTH (month, day, and year) Oct 19-1850

7 AGE — Years 72 — Months 6 — Days 10 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Johan Kirschbel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Bankenoor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Gustav E. Schwanetzke

(Address) 2113 Mc Henry St

15 Filed APR 30 1929 — HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24, 29

17 I HEREBY CERTIFY, That I attended deceased from 11/5/ 1928, to 4/29- 1929, that I last saw h alive on April. 29- 1929 and that death occurred, on the date stated above, at 3.25 P.M.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis —

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical Diagnosis

(Signed) B Welby Hemming M. D.

4/29 1929 (Address) 2000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Western Cemetery — May 2 19 29

20 UNDERTAKER — ADDRESS

H. B. Weyant — 1850 W. Baltimore St

NOTE—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45524

CERTIFICATE OF DEATH

52 ✓

E 45524

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3704 Garrison Ave ST. 15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Hannah Noll

(a) RESIDENCE NO. 3704 Garrison Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William Noll

6 DATE OF BIRTH (month, day, and year): April 27-1866

7 AGE: Years 63 | Months — | Days 2 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Henry Baenter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary Schneidmiller

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: William J. Noll

(Address) 4205 Glenmore Ave

15 Filed ....., 19.... HAMPSON JONES, M. D. Registrar

APR 30 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 29 29

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1926, to April 29, 1929, that I last saw h— alive on April 28th, 1929, and that death occurred, on the date stated above, at 5:20 A.M.

The CAUSE OF DEATH* was as follows:

I Hypostatic Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Arthritis Deformans to my knowledge

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Physical

(Signed) H. L. Keyser M. D.

4-29-1929 (Address) Wentworth Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park | DATE OF BURIAL: May 1. 1929

20 UNDERTAKER: Wm. Miss John H. Teufel & Son | ADDRESS: 801 N. Fayette St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45525

CERTIFICATE OF DEATH.

188-103

E 45525
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph Hos. St. 10-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Christine Thompson.

(a) RESIDENCE NO. 1213 N. Spring St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos.

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug 3 - 1920

7 AGE — Years: 8 — Months: 8 — Days: 23 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at School

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Md.

(State or country)

PARENTS

10 NAME OF FATHER: Joseph Thompson

11 BIRTHPLACE OF FATHER (city or town): Md.

(State or country)

12 MAIDEN NAME OF MOTHER: Ella Woodley

13 BIRTHPLACE OF MOTHER (city or town): Md.

(State or country)

14 Informant: Joseph Thompson (Address) 1213 N. Spring St.

Filed APR 30 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr. 26 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull - Accidentally Struck By automobile at Biddle & Spring Sts

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Inquest Apr 29/29

(duration) .....yrs. .....mos. .....ds.

(Signed) [illegible] M. D.
(Coroner)

19. (Address) 4/29/29 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.,.....ds. In the State.....yrs.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ashury Cemetery Date of Burial: Apr. 30 1929

20 UNDERTAKER: Chas. T. Johnson ADDRESS: 446 N. Carolina St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

Lerner

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45526 100-001 **E 45526**

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of Baltimore: (No. Sinai Hospital St., 2-4 Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mendal Lerner

(a) RESIDENCE NO. 2031 E Balto. St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	white	widiwer

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sophie Lerner

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	70			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Russia

PARENTS

10 NAME OF FATHER Fisnel Lerner

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Mollie ------

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Jack Lewis
(Address) 1439 E. Balto., St

15 Filed ..., 19.. C. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 29/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to .his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) ..yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Senility-Cardiac Failure

(duration) ..yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J Sol Hamm, M. D.

4/29/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Herrn Woodlawn	4/30 19 29
20 UNDERTAKER	ADDRESS
Jack Lewis	1439 E Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

APR 30 1929

Cor.—10-10-29—A Co.—100 Bks.

Kershman

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

45527 E

E 45527

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Sinai Hospital St. 14-59 Ward 199

2-FULL NAME Rose Kershman

(a) RESIDENCE NO. 2149 Division St., Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Philip Kershman

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	28			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Russia

PARENTS

10 NAME OF FATHER Frank Zelic Overak

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Russia

14 Informant Philip Kershman
(Address) 2149 Division St.

15 Filed ..... G. HAMPSON JONES, M. D. Registrar

APR 30 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 29/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

General Septicemia (Staphylococcic)
(Designed abortion. Patient refused to state who performed same)

..... (duration) ..... yrs. ..... mos. 11 ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) J. S. H. Green M. D.

4/29/29 (Address) 506 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mortuary circle Cem

DATE OF BURIAL 4/30 1929

20 UNDERTAKER Jack Lewis

ADDRESS 1489 Edmondson Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45528

CERTIFICATE OF DEATH.

112 E 45528

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1115 Woodyear St. 16-23 WARD)

2-FULL NAME Julia Johnson Arthur

(a) RESIDENCE: No. 1115 Woodyear ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 ~~Single~~, Married, Widowed, or ~~Divorced~~ (write the word): Married

5a If married, widowed, or divorced HUSBAND ~~of~~ (or) WIFE of: Charles Arthur

6 DATE OF BIRTH (month, day, and year): 1888

7 AGE: Years 41; Months —; Days —; If LESS than 1 day, hrs. or min. —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Richmond, Va

PARENTS

10 NAME OF FATHER: James Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Richmond Va

12 MAIDEN NAME OF MOTHER: Isabella Herbert

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Richmond Va

14 Informant (Address): Charles Arthur 1115 Woodyear St

15 [illegible]

16 [illegible]

HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/29 1929

17

I HEREBY CERTIFY, That I attended deceased from 4/25 1929 to 4/29 1929, that I last saw her alive on 4/29/29 1929, and that death occurred, on the date stated above, at 7 PM

The CAUSE OF DEATH* was as follows:

Acute Gastritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Improper Diet

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1115 Woodyear

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) M Boston, M. D.

1929 (Address) 1512 Gilmor

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	May 1 1929
UNDERTAKER	ADDRESS
Virginia A Brooks	1463 N. Carey

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

APR 30 1929

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45529

CERTIFICATE OF DEATH

10-002

E 45529
REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital, W-L-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Howard W. Harvey

(a) RESIDENCE NO. 417 S. Furrow ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 22, 1926

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER William H. Harvey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Reva I Dowell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant William H. Harvey
(Address) 417 S. Furrow St.

15 Filed APR 30 1929, 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 29, 1929, to April 29, 1929, that I last saw h. alive on April 29, 1929 and that death occurred, on the date stated above, at 11 45 a.m.

The CAUSE OF DEATH* was as follows:

Diphtheria (Tonsillar & Laryngeal)

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Acute Diphtheritic Myocarditis (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? 417 S. Furrow St.

Did an operation precede death? None Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clynical findings

(Signed) Addison Craft Oakley, M. D.

4-29 1929 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet Cemetery — DATE OF BURIAL Apr. 30 1929

20 UNDERTAKER George L. Schmidt — ADDRESS 701 Fredk. Ave.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45530

CERTIFICATE OF DEATH

44

E 45530

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 3446 Leverton Av ST., 26-37 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Francis H. Wells

(a) RESIDENCE NO. 3446 Leverton Av ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Nellie Wells

6 DATE OF BIRTH (month, day, and year): apr. 13/58

7 AGE — Years: 71 — Months: — — Days: 13 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Public Bath

(b) General nature of industry, business, or establishment in which employed (or employer): Keeper

(c) Name of employer: Pattelson Pk.

9 BIRTHPLACE (city or town) (State or country): Wash. D.C.

PARENTS

10 NAME OF FATHER: Jas. Wells

11 BIRTHPLACE OF FATHER (city or town) (State or country): D.C.

12 MAIDEN NAME OF MOTHER: Ella V. Benson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): D.C.

14 Informant: Nellie Wells

(Address) 3446 Leverton Av

15 Filed APR 30 1929, 19

C. HARRISON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 28/29

17 I HEREBY CERTIFY, That I attended deceased from Apr 2, 1929, to Apr 28, 1929

that I last saw h[illegible] alive on Apr 28, 1929

and that death occurred, on the date stated above, at 6:30 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma.

Not known.
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis Not known how
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X Ray

(Signed) M. Ephraim, M. D.

. 19 (Address) 1904 E Bnlt St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cem.

DATE OF BURIAL: May 1929

20 UNDERTAKER: Philip Herwig

ADDRESS 2016 Eutaw

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45531

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49 E 45531

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2650 Oswego Ave ST. 15-6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Maurice J. O'Neill

(a) RESIDENCE NO. 2650 Oswego Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alma B. O'Neill

6 DATE OF BIRTH (month, day, and year) Sept. 25/1896

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
32	7	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Millinary

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER John C. O'Neill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Katherine French

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Alma B. O'Neill

(Address) 2650 Oswego Ave

15 C. HAMPSON JONES, M. D. Registrar

APR 30 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28/29

17 I HEREBY CERTIFY, That I attended deceased from Apr 1, 1929, to Apr 23, 1929, that I last saw h. alive on Apr 23 1929 and that death occurred, on the date stated above, at 6.40 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of Rectum

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of Apr 3 29

Was there an autopsy? No

What test confirmed diagnosis? Microscopic

(Signed) Geo Warren, M. D.

, 19 (Address) 16 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London PK Cem.

DATE OF BURIAL May 2 1929

20 UNDERTAKER Philip Herwig

ADDRESS 2040 Aliceanna St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

Agnes C Wagner

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45532

CERTIFICATE OF DEATH

31

E 45532

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 331 E. Lorraine Ave ST. 12-50 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Agnes C. Wagner

(a) RESIDENCE NO. 331 E. Lorraine Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of I. LeRoy Wagner

6 DATE OF BIRTH (month, day, and year) Nov. 25, 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	44	5	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Richmond (State or country) Virginia

PARENTS

10 NAME OF FATHER B. V. Connolly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Katherine McDonn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mr. I. LeRoy Wagner

(Address) 331 E. Lorraine Avenue

15 Filed APR 30 1929, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 27th, 1929, to April 29th, 1929, that I last saw her alive on April 28th, 1929 and that death occurred, on the date stated above, at 1.30 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted? If not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Findings

(Signed) Henry Kleibel M. D.
Edwin Flossing M. D.

4/29/1929 (Address) 1224 Hanover St. Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL May 1 19 29

20 UNDERTAKER Joseph B Cook

ADDRESS 1003 West Baltimore St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Grove

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45533

CERTIFICATE OF DEATH

91-002

E 45533

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1909 Deering Ave. ST., 25-7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Susan J. Grove

(a) RESIDENCE NO. 1909 Deering Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Albert D. Grove

6 DATE OF BIRTH (month, day, and year) March 3, 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	84	1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Abbottstown, Adam Co. Pennsylvania

PARENTS

10 NAME OF FATHER David Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Harriet Hafer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Mr. William H. Kelley

(Address) 1909 Deering Ave.

15 Date received APR 30 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28, 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan. 30, 1929, to Apr. 28, 1929, that I last saw h... alive on Apr. 28, 1929 and that death occurred, on the date stated above, at 2.15 A. m.

The CAUSE OF DEATH* was as follows:

Senility

Arteriosclerosis

1

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemic Coma

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jno. P. Byerly, M. D.

4/29, 1929 (Address) 3045 W. North Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL Apr. 30 1929

20 UNDERTAKER Adolph Cook

ADDRESS 1003 West Baltimore St

Notice should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

Sister Joseph death Maria ✓

E 45534 HEALTH DEPARTMENT—CITY OF BALTIMORE **E 45534**

CERTIFICATE OF DEATH.

90

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST. 10-1 WARD)

2-FULL NAME Sister Joseph de Ste Marie

(a) RESIDENCE NO. Preston + Valley ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 29th 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Religious

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) France

PARENTS

10 NAME OF FATHER Francois Nicholas

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER M. L. Louis Colly

13 BIRTHPLACE OF MOTHER (city or town) (State or country) France

14 Informant Little Sisters of the Poor

(Address) Preston + Valley St

APR 30 1929 C. HAMPSON JONES, M. D.
(Registrar)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 24 1929

17

I HEREBY CERTIFY, That I attended deceased from Dec 15, 1928, to April 29 1929,

that I last saw h alive on ....., 19 ,

and that death occurred, on the date stated above, at 3:30 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

Unknown (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY
(Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ..... Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Bernard Wall, M. D.

4/30 1929 (Address) 1216 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL May 1 1929

20 UNDERTAKER Rita Wiedefeld — ADDRESS 914 Greenmount Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45535

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 45535

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joel Jonas

(a) RESIDENCE NO. 1006 N. Eutaw st. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Separated

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER Joseph Jonas

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Mathilda Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant Hospital Records
(Address)

15 Filed APR 30 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 26, 1929, to April 28, 1929, that I last saw him alive on April 28, 1929 and that death occurred, on the date stated above, at 2.15 p. m.

The CAUSE OF DEATH* was as follows:

Tuberculous pneumonia

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical and autopsy

(Signed) Henry C. Smith M. D.

4-29 1929 (Address) Baltimore City Hospitals.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Calvary	April 30 1929
20 UNDERTAKER Wm. A. Elliott	ADDRESS 1725 Ashland Ave

Before signature should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 45536

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45536

CERTIFICATE OF DEATH

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH

City of Baltimore: (No.) Balto City Hospital St. (or Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lerman H Barton

(a) RESIDENCE NO. Balmoral Ave Bear Creek St., Md. Ward

(Usual place of abode) Removed to 416 S. Wolfe (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Mal	Wht	Sngl

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 18th 1922

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	7	0	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto Co.

PARENTS

10 NAME OF FATHER Jesse K. Barton

11 BIRTHPLACE OF FATHER (city or town) Penna
(State or country)

12 MAIDEN NAME OF MOTHER Annie E. Bauman

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country)

14 Informant Jesse K. Barton (Father)
(Address) Balmoral Ave Bear Creek Md.

APR 30 1929

C. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Acute Peritonitis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Injured Scalp by Accident

Small Pox (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? City Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James W Benton M. D.

4-29 1929 (Address) 700 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Md. Holy Redeemer Cem — DATE OF BURIAL: May 2 1929

20 UNDERTAKER: Lilly & Geiler Inc. — ADDRESS: 403 S. Wolfe

Spec.—2-29-28—L. F. S.—500 Bks.

E 45537 HEALTH DEPARTMENT—CITY OF BALTIMORE E 45537

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 7637

CITY OF BALTIMORE: (No. 3301 Tilton ST. 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Magdalena Schatz

(a) RESIDENCE NO. 3301 Tilton ST., 26 WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

a If married, widowed, or divorced HUSBAND of (or) WIFE of Anton Schatz

6 DATE OF BIRTH (month, day, and year) Nov 21 1870

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
58	5	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER George Norbert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Keller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Bernard Schatz

(Address) 3301 Tilton St.

APR 30 1929 C. HAMPSON JONES, M. D. 19 ...

Per ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29/29

17 I HEREBY CERTIFY, That I attended deceased from February 17, 1929, to April 29, 1929, that I last saw her alive on April 29, 1929 and that death occurred, on the date stated above, at 4:15 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Carl E. Peters, M. D.

April 29 1929 (Address) 130 E. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cemetery	May 1 1929
20 UNDERTAKER Lilly & Sievers	ADDRESS 405 N. Wolfe St

IMPORTANT—Physicians are earnestly requested to fill out this certificate promptly and accurately. ALL blanks should be filled. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 45538

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45538

CERTIFICATE OF DEATH

90

1—PLACE OF DEATH

REGISTERED NO. 15-65

CITY OF BALTIMORE: (No. 2857 W. North Ave. ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lavenia McCabe

(a) RESIDENCE NO. 2857 W. North Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. 4 mos. 7 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

a If married, widowed, ~~or divorced~~ HUSBAND of (or) WIFE of Wm. H. McCabe

6 DATE OF BIRTH (month, day, and year) Dec. 22. 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	74	4	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Benjiman Sitzler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Catherine Shebeck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Mrs. C. F. Wortman
(Address) 2857 W. North Ave

15 J. HAMPSON JONES, M. D.
Registrar

APR 30 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29-29

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1928, to April 29, 1929, that I last saw her alive on April 28, 1929, and that death occurred, on the date stated above, at 2.59 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
Ulcer of Stomach
(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart Failure
(duration) yrs. mos 3 ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Thos E Shehan, M. D.

4/30 1929 (Address) 244 Longwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	May 2 1929
20 UNDERTAKER Harry W. Ehlen	ADDRESS 6 E North Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 45539

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45539

CERTIFICATE OF DEATH.

182

1-PLACE OF DEATH Found = Harbor at

City of BALTIMORE: (No. Foot of Gould St., 3-4 Ward)

2-FULL NAME unknown

(a) RESIDENCE NO. unknown St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	about 30			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Probably Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) unknown

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) unknown

14 Informant

(Address)

15 Filed 4-4 19

C. HARRISON JONES, M. D.

Per Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/2/29

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

Sudden

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) James M Fenton M. D.

(Coroner)

4 28 1929 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY. Date of Burial APR 30 1929

20 UNDERTAKER Commissioner Health.

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

4-6

E. M. WOODALL

Spec.—1-10-21—M&T—1500 Blks.

E 45540 HEALTH DEPARTMENT—CITY OF BALTIMORE E 45540

CERTIFICATE OF DEATH.

X 75-001

1-PLACE OF DEATH Sinai Hospital REGISTERED NO. 7-13

CITY OF BALTIMORE: (No. ..... ST., ... WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Newbury

(a) RESIDENCE NO. 844 W. State ST., Trenton, N. J. WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Newbury

6 DATE OF BIRTH (month, day, and year) July 14, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	65	9	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mgr. Wire Rope Mfg

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) U. S.

PARENTS

10 NAME OF FATHER Alexander M. Newbury

11 BIRTHPLACE OF FATHER (city or town) (State or country) U. S.

12 MAIDEN NAME OF MOTHER Elvina Hyppe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) U. S.

14 Informant Irvin F. Taylor
(Address) Trenton, N. J.

15 HAMPSON JONES, M. D. Registrar

R 30 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 29 1929

17 I HEREBY CERTIFY, That I attended deceased from 4/17, 1929, to April 29, 1929, that I last saw h[illegible] alive on April 29, 1929, and that death occurred, on the date stated above, at 8.50 P. m.

The CAUSE OF DEATH* was as follows:

Cyclone pneumonia

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Partial Anuria Left Sided Hemiplegia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) C. Hyppe, M. D.

, 19 (Address) Sinai Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trenton, N. J.	Apr 30, 29
20 UNDERTAKER	ADDRESS
Wm. J. Tickner & Son	Mott & Pa.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 45541

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45541

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2906 Baker St. 15-61 WARD)

2-FULL NAME Theophilus L. Barnes.

(a) RESIDENCE NO. 2906 Baker ST., WARD Ellicott City Md
(Usual place of abode)
Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced. (write the word) Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary G. Barnes.

6 DATE OF BIRTH (month, day, and year) Dec 12. 1863

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
65	10	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) Own

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Thomas Barnes.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Mary Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Mrs. Anna Schaffner
(Address) 2906 Baker St.

R 30 1929

C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29 1929

17 I HEREBY CERTIFY, That I attended deceased from June, 1928, to April 29, 1929, that I last saw h in alive on April 29, 1929, and that death occurred, on the date stated above, at 7? m.

The CAUSE OF DEATH* was as follows:

Myocardial Insuff.

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? Clinical & Lab.

(Signed) Isidor S. Long M. D.

Apr., 1929 (Address) 2324 Eastern Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

D. Wms Cem.

DATE OF BURIAL May 2 1929

20 UNDERTAKER Easton Sons

ADDRESS Ellicott City

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Dr White 2800 St Paul St

E 45542

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45542

CERTIFICATE OF DEATH

57

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3009 Clear View Ave, Homelan ST. 27-43 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Snyder

(a) RESIDENCE NO. 3009 Clear View Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of: Walter E Snyder

6 DATE OF BIRTH (month, day, and year): Dec 6, 1889

7 AGE: Years 39 | Months 4 | Days 23 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 37

(c) Name of employer: At Home

9 BIRTHPLACE (city or town) (State or country): Bush Me

PARENTS

10 NAME OF FATHER: Lenard M Browne

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bush Me

12 MAIDEN NAME OF MOTHER: Carrie Schlinet

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bush Me

14 Informant: Walter E Snyder

(Address) 3009 Clear View Ave

15 Filed 1929 C. HAMPSON JONES, M. D., Registrar

Per DPH

PR301929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 29, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 4, 1928, to April 29, 1929, that I last saw h alive on April 28, 1929 and that death occurred, on the date stated above, at 9 a m.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary): Hypertonis - Coma -

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? / Date of

Was there an autopsy? /

What test confirmed diagnosis? /

(Signed) Walter W White, M. D.

Apr 30, 1929 (Address) 2800 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: May 2 1929

20 UNDERTAKER: B. M. Cook

ADDRESS: 1212 Eutaw St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

H Jones

E 45543

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

2400

E 45543

REGISTERED NO. .....

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1843 N Hope ST. 9-18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emma F Myers

(a) RESIDENCE NO. 1843 N Hope ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Otis Myers

6 DATE OF BIRTH (month, day, and year) Sept. 1852

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
75	7	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs Emma Cisel
(Address) 1843 N Hope St

15 Filed ..... 19 HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 28. 1929

17 I HEREBY CERTIFY, That I attended deceased from Apr 27, 1929, to Apr 28, 1929, that I last saw h alive on Apr 28 1929 and that death occurred, on the date stated above, at 8.45 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) H G Jones, M. D.

4/29, 1929 (Address) 720 N. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Union Cem

DATE OF BURIAL: 5/1 1929

20 UNDERTAKER: [illegible] Cook

ADDRESS: 1217 N Pine St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

R 30 1929

Spec.—1-10-21—M&T—1500 Blks.

E 45544

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45544

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 528 W. Biddle ST. 17-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Isid Green

(a) RESIDENCE NO. 528 W. Biddle ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): April 27 1929

7 AGE: Years — Months — Days 1 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Daniel Green

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Elizabeth Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Essex, Va.

14 Informant: Elizabeth Green (Address): 528 W. Biddle St.

15 Filed APR 30 1929 C. HAMPSON JONES, M. D. Registrar 3525

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 28 1929

17 I HEREBY CERTIFY, That I attended deceased from April 27, 1929, to April 27, 1929, that I last saw her alive on April 27, 1929, and that death occurred, on the date stated above, at 6:30 A.m.

The CAUSE OF DEATH* was as follows:

Intra cranial hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Maternal Lues.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Louis E. Douglass M. D.

April 27, 1929 (Address) Maternity Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Removal

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS APR 30 192

UNIVERSITY OF MARYLAND

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45545 HEALTH DEPARTMENT—CITY OF BALTIMORE E 45545

CERTIFICATE OF DEATH

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

1—PLACE OF DEATH

REGISTERED NO. 31

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST., 17 B. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Arthur Peterson

(a) RESIDENCE NO. 718 Pennsylvania ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Separated

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Corriene Peterson

6 DATE OF BIRTH (month, day, and year) 1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10 NAME OF FATHER Mose Peterson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records

(Address)

15 Filed ..... 19 C. HAMPSON JONES, M. D. Registrar

Per 3526 MRK

PR 301929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 27, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 24, 19 29, to April 27, 19 29, that I last saw him alive on April 27, 19 29 and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical and Lab.

(Signed) Kemp Smith, M. D.

4-27. 19 29 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

APR 30 1929

Spec.—2-29-28—L. F. S.—500 Bks.

E 45546 HEALTH DEPARTMENT—CITY OF BALTIMORE E 45546

CERTIFICATE OF DEATH

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

CITY OF BALTIMORE: (No. [redacted] ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Chaillon

(a) RESIDENCE NO. 1120 Montford Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Agustus Chaillon

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Eliza Cummins

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Records of UNIVERSITY OF BALTIMORE CITY H[redacted]

15 Filed [redacted] C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 24, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 10, 19 29, to April 24, 19 29, that I last saw h[redacted] alive on April 24, 19 29 and that death occurred, on the date stated above, at 1:50 A.m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration
Myocardial insufficiency

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? Physical Exam

(Signed) H. M. Hall, M. D.

, 19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
UNIVERSITY OF MARYLAND	APR 30 1929
20 UNDERTAKER	ADDRESS
[illegible]	

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Dr Fusha 1809 N Patterson Park Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45547

CERTIFICATE OF DEATH

90 E 45547

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1809 N. Patterson Park Ave ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Colvin Payne

(a) RESIDENCE NO. 1809 N Patterson Park Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella M. Payne

6 DATE OF BIRTH (month, day, and year) Dec 26. 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER William Payne

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary L. Maynard

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Mrs. C. Payne

(Address) 1809 N Patterson Park Ave

15 Filed Apr 3 1929 C. HAMPSON JONES, M. D. Registrar

Per ARH

PR 30 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 29. 1929

17 I HEREBY CERTIFY, That I attended deceased from Mar. 20, 1929, to Mar. 29, 1929, that I last saw him alive on Mar. 29, 1929 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(duration) 12 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jacob Fusha, M. D.

Apr 30 1929 (Address) 1823 N. Wash St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet

DATE OF BURIAL 5 2 1929

20 UNDERTAKER D. W. Cook

ADDRESS 27 St Paul

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Dr Woody, 1423 Park Ave

E 45548

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45548

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1811 St Paul Ave ST., 8-16 WARD)

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Bernard Blizzard

(a) RESIDENCE NO. 1811 St Paul Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occur 43 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Cora M. Blizzard

6 DATE OF BIRTH (month, day, and year) Aug 15, 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44	7	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Captain

(b) General nature of industry, business, or establishment in which employed (or employer) Steam Boat

(c) Name of employer U. S. Govt

9 BIRTHPLACE (city or town) (State or country) Crisfield Md

PARENTS

10 NAME OF FATHER John Blizzard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary Boon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Cora M. Blizzard

(Address) 2508 Eastern Ave

15 Filed 1929 C. HAMPSON JONES, M. D. Registrar.

PR 30 1929 Pct. RCH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Mar 27, 1929

17 I HEREBY CERTIFY, That I attended deceased from 4/26, 1929, to 4/28, 1929, that I last saw h alive on 4/28/29, 1929, and that death occurred, on the date stated above, at 4:30 P.M. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Mitral Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) W. H. Woody, M. D.

, 19 (Address) 1403 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park

DATE OF BURIAL 5/1, 19 29

20 UNDERTAKER W. M. Cook

ADDRESS 1217 E. Baltimore St

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

George.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45549

CERTIFICATE OF DEATH

90 ✓

E 45549

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1118 N. Fulton ST. 16-2 WARD)

2—FULL NAME Anderson George

(a) RESIDENCE NO. 1118 N. Fulton ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed, or Divorced~~, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine George

6 DATE OF BIRTH (month, day, and year) Nov 25 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	5	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer) Decorating

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Francis George

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Rose Kirchenbaum

(Address) 1839 N. Chester St

15 Filed MAY 1 - 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29, 1929

17 I HEREBY CERTIFY, That I attended deceased from September 26 1928 to April 29 1929

that I last saw him alive on April 29 1929

and that death occurred, on the date stated above, at 1145 A. m.

The CAUSE OF DEATH* was as follows:

Aortic Insufficiency

Arterial Hypertension

(duration) Yrs. mos. da.

CONTRIBUTORY (Secondary) Cardiac dilatation

(duration) yrs. mos. 8 da.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Typical Examination

(Signed) Albert Ehrenberg M. D.

4/30, 1929 (Address) 2035 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Burwood Cem	May 2 1929
20 UNDERTAKER	ADDRESS
Geo. L. Ruth	1923 Eastern Ave

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45550

CERTIFICATE OF DEATH.

156 E 45550

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) President Hosp ST. 1724 WARD)

2-FULL NAME Louis Parker

(a) RESIDENCE No. 603 W Biddle St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) July 1728

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		10	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Louis Parker.

11 BIRTHPLACE OF FATHER (city or town) (State or country) md.

12 MAIDEN NAME OF MOTHER Louisa Parker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Louis Parker.

(Address) 603 Biddle st

Filed 1929 C. HAMPSON JONES, M. D., Registrar

Par 100

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-30 1929

17 I HEREBY CERTIFY, That I attended deceased from 4-12, 1929, to 4-30, 1929, that I last saw h alive on 4-30, 1929, and that death occurred, on the date stated above, at 7.45 a. m.

The CAUSE OF DEATH* was as follows:

Erysipelas

(duration) yrs. mos 17 ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? unk

Did an operation precede death? yes Date of 4-22-29

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Palmer, M. D.

4/30 1929 (Address) President Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn cem	5-1 1929
20 UNDERTAKER Daniel Easter	ADDRESS 916 Ca ave

REMOVAL SHOULD BE STRICTLY SUPPLIED. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AY

Spec.—2-29-28—L. F. S.—500 Bks.

E 45551

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-08

E 45551

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Baltimore City Hospital ST., 7 26 WARD)

2—FULL NAME John Watkins

(a) RESIDENCE NO. 718 Little George ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 6 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced BUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Records of

(Address) BALTIMORE CITY HOSPITALS

15 Filed MAY 1 - 1929 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 29, 1929

17 I HEREBY CERTIFY, That I attended deceased from December 18, 19 26 to April 29, 19 29, that I last saw him alive on April 29, 19 29 and that death occurred, on the date stated above, at 10:10 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage or Thrombosis of Cerebral Artery

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Decubitus Ulcers

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) R. Ed Heck, M. D.

, 19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: 5-1-1929

20 UNDERTAKER: Dennis Easton — ADDRESS: Balto

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45552

CERTIFICATE OF DEATH.

9 E 45552

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH 316 - W. 28th

CITY OF BALTIMORE: (No. James C. Winder ST. 1251 WARD)

2-FULL NAME James C. Winder

(a) RESIDENCE No. 316 W. 28th ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: None

6 DATE OF BIRTH (month, day, and year): July 8 1928

7 AGE: Years | Months: 9 | Days: 21 | If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ellicott City, Md

PARENTS

10 NAME OF FATHER: James Winder

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Ella Stokes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Jas Winder

(Address): 316 W 28th St

15 Filed MAY 1 - 1929 C. HAMPSON JONES, M. D. Registrar

By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/29 1929

17 I HEREBY CERTIFY, That I attended deceased from 4/25 1929, to 4/29 1929,

that I last saw h— alive on 4/29 1929,

and that death occurred, on the date stated above, at 11 A M

The CAUSE OF DEATH* was as follows:

Whooping Cough + Pneumonia (Colon)

Pneumonia — (duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Burk Clutter, M. D.

4/30, 1929 (Address) 2139 O St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem DATE OF BURIAL: 5/1/29

20 UNDERTAKER: Samuel T Beverley ADDRESS: 378 N Bond

INFORMATION should be entirely supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45553

CERTIFICATE OF DEATH

118-002

E 45553

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Johns Hopkins Hospital St., 5-8 Ward)

2-FULL NAME Hester E. Frazier

(a) RESIDENCE NO. 1140 Low St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	black	widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	50			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) Snow Hill, Md.
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Snow Hill, Md

PARENTS

10 NAME OF FATHER Lewis H. Fletcher

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Hester Johnson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant John Goldsborough
(Address) 1146 Low St.

15 Filed MAY 1 - 1929 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Volvulus Mesentery - Gangrene of small Intestine

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? At Hopkins

What test confirmed diagnosis?

(Signed) [signature], M. D.

5/1/29 (Address) 508 E. Monument Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Calvary	5/3/ 1929
20 UNDERTAKER Samuel D. Buckley	ADDRESS 578 N Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45554

CERTIFICATE OF DEATH

101-001

E 45554

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1005 Creek St. 23-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Cohen

(a) RESIDENCE NO. 1005 Creek St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. 1 mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer) 074

(c) Name of employer

9 BIRTHPLACE (city or town) Greensboro
(State or country) N. Carolina

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Jessie Neal
(Address) 154 W Hamburg

15 4-1-1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/28/29

17

I HEREBY CERTIFY, That I attended deceased from 4/22, 1929, to 4/28, 1929, that I last saw him alive on 4/28, 1929 and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) — yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? W Date of

Was there an autopsy? W

What test confirmed diagnosis? Unk

(Signed) D. A. Strauchen, M. D.

4/29 1929 (Address) 122 W Lee

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	5/1 1929
20 UNDERTAKER Harold D. Hawley	ADDRESS W Balto 578

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

153

E 45555

1—PLACE OF DEATH

REGISTERED NO. E 45555

CITY OF BALTIMORE: (No. University Hospital ST., 11-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Michael McFillen

(a) RESIDENCE NO. 113 N Monroe ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

(a) If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: the late Rosanna Mc Fillen

6 DATE OF BIRTH (month, day, and year): May 14th 1873.

7 AGE — Years: 55 | Months: 11 | Days: 15 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Capt Kaps

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Ireland.

PARENTS

10 NAME OF FATHER: James Mc Fillen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland.

12 MAIDEN NAME OF MOTHER: Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland.

14 Informant: Mrs Edward Kelley

(Address): 113 N Monroe St

15 Filed MAY 1 - 1929. 16 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 29th 1929

17 I HEREBY CERTIFY, That I attended deceased from April 27th, 1929, to April 29th, 1929, that I last saw him alive on April 29th, 1929, and that death occurred, on the date stated above, at 11 55 P. m.

The CAUSE OF DEATH* was as follows:

Cellulitis left side of neck.

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Septicemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Louis P. Gundry, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem.

DATE OF BURIAL: May 3rd, 1929

20 UNDERTAKER: John J Cowan & Son

ADDRESS: 401 Hollins St

IMPORTANT. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 45567

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

32 E 45556

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 1420 WARD)

2-FULL NAME James Hunter

(a) RESIDENCE No. 1133 Division ST., St WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12/16/20

7 AGE — Years: 8 — Months: 4 — Days: 13 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: — school

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer: 0

9 BIRTHPLACE (city or town) (State or country): Md —

PARENTS

10 NAME OF FATHER: James Hunter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va —

12 MAIDEN NAME OF MOTHER: Willie Agnes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va —

14 Informant: Records —

(Address) JOHNS HOPKINS HOSPITAL

15 [illegible] 1929 C. HAMPSON JONES, M. D. Registrar

Per [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28 1929

17 I HEREBY CERTIFY, That I attended deceased from April 24 1929 to April 28 1929.

that I last saw him alive on April 28 1929,

and that death occurred, on the date stated above, at 8 25 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculous meningitis

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary): none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis? Spinal puncture, tuberculosis

(Signed) J. C. Gaglwin, M. D.

4/30, 1929 (Address) J. H. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary — DATE OF BURIAL: May 3 1929

20 UNDERTAKER: Mrs. H. G. Elliott — ADDRESS: 1722 Eastlund

MAY 1 - 1929

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45557

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49 E 45557

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1612 Mc Elderry ST. 7-9 WARD)

2—FULL NAME Edward Young

(a) RESIDENCE NO. 1612 Mc Elderry ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. Life ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Married

3a If married, widowed, or divorced HUSBAND of (or WIFE of) Emmaline Young

6 DATE OF BIRTH (month, day, and year) Feb 26 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer): Farm. O&O

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Geo Young

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mrs Fannie Ruffey (daughter)
(Address) 1612 Mc Elderry st

15 Filed MAY 1 - 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 27 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec, 1928, to April 27 1929, that I last saw h. alive on April 27 1929, and that death occurred, on the date stated above, at 11.50 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Bladder.

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Hemmorhages from Bladder

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? Uncertain

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical & Laboratory

(Signed) R. J. Young, M. D.

4/28 1929 (Address) 1429 Eutaw st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stevens Cem. DATE OF BURIAL: May 1929

20 UNDERTAKER: Mrs. R. G. Elliott ADDRESS 1725 Eastlund Ave

Important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

E 45558 — 5 / E 45558

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1303 N. Bruce St. 5-27 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Wesley Parker

(a) RESIDENCE. No. 1303 N. Bruce St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 ~~Single, Married, Widowed,~~ or Divorced (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Bell Parker

6 DATE OF BIRTH (month, day, and year): 1879

7 AGE — Years: 50 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): West Indies Island B.C.

PARENTS

10 NAME OF FATHER: Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER: Ellen Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country): West Indies Island

14 Informant: Belle Parker. (Address) 1303 n Bruce st.

15 Filed — C. HAMPSON JONES, M. D. Registrar — By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 28 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb 13, 1929, to April 28, 1929, that I last saw him alive on April 27, 1929, and that death occurred, on the date stated above, at 9:55 A m.

The CAUSE OF DEATH* was as follows: Acute Articular Rheumatism

(duration) yrs. 2 mos. 15 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) W. T. Coleman M. D.

April 29, 1929 Address 1039 N. Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery — DATE OF BURIAL: May 1 1929

20 UNDERTAKER: Thomas E. Kelson. — ADDRESS: 1303 Pressman St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAY 1 - 1929

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45559

E 45559

CERTIFICATE OF DEATH

129

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1604 Lemon St. ST. 19-28 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna K. Rahe Kleinschmidt

(a) RESIDENCE NO. 1604 Lemon St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Kleinschmidt

6 DATE OF BIRTH (month, day, and year) Jan. 24, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	3	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Miersch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Frederick Rahe

(Address) 1604 Lemon St.

15 5-1-1929, 19 C. HAMPSON JONES, M. D.

Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr. 29. 1929

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1929, to Apr. 29, 1929, that I last saw h.. alive on Apr. 29, 1929, and that death occurred, on the date stated above, at 10.45 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) none

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Clinical Findings

(Signed) C. Hampson Jones, M. D.

5/1/29 19 (Address) 887 W. Lemon St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL May 1/29

20 UNDERTAKER Harry S. White

ADDRESS 1531 W. Lombard St.

Be sure to fill in all items, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 45560 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 45560

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) Balto. City Hospitals ST., 12-19 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Lundy

(a) RESIDENCE NO. 402 E. Preston ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James Lundy

6 DATE OF BIRTH (month, day, and year): Sept 27/1855

7 AGE: Years 73 | Months 7 | Days 3 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child's Nurse

(b) General nature of industry, business, or establishment in which employed (or employer): 66

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: James Hanly

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Finneran

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Records of

(Address): Balto City Hospital

15 Filed MAY 1 1929 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 30, 1929

17 I HEREBY CERTIFY, That I attended deceased from February 25, 19 29 to April 30, 19 29

that I last saw her alive on April 30, 19 29

and that death occurred, on the date stated above, at 6:00 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Myocardial Insufficiency

Several weeks (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. S. Mack, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Joseph's Cem. Texas Md. DATE OF BURIAL: May 3 19 29

20 UNDERTAKER: Wade H. Evans & Son ADDRESS: 1187 W. Mt. Royal Ave.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45561

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-002

E 45561

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Tudor Hall Apartment ST. 17-49 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ida Christine Deshon Ridgely

(a) RESIDENCE NO. Tudor Hall Apartments ST. WARD Resident
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. 7 mos. 20 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Dr. Nicholas G. Ridgely

6 DATE OF BIRTH (month, day, and year) Sept-9-1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Christopher Deshon

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Ratcliffe

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mrs. R. I. Flick (daughter)
(Address) 1016-5th Ave, New York City, N.Y.

15 MAY 1 - 1929

C. HAMPSON JONES, M. D.

For

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29-1929.

17 I HEREBY CERTIFY, That I attended deceased from March 29, 1929, to April 29, 1929, that I last saw h[illegible] alive on April 29, 1929 and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Acute Decompensation of Heart - Multiple Pulmonary Infarctions. Cerebral Embolism

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Chronic Arthritis Deformans Bed ridden (duration) 25 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) M. Gibson Forler, M. D.

1929 (Address) 4822 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL May 1 1929

20 UNDERTAKER STUART C. MOWEN COMPANY
(WILLIAM F. WOODEN, Supervisor)

ADDRESS 103 W. NORTH AVE

The above is to be filled in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45562

E 45562

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2514 Hamilton Ave (St.) 27-13 (WARD) 24

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William F. Welsh

(a) RESIDENCE No. 2514 Hamilton Ave (St.) WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Regina Welsh

6 DATE OF BIRTH (month, day, and year): Nov. 9, 1863

7 AGE — Years: 66 Months: 0 Days: 19 If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired fireman

(b) General nature of industry, business, or establishment in which employed (or employer): City Fire Dept

(c) Name of employer: Balto 0-32

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Thomas Welsh

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary E. Hughes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Regina Welsh

(Address) 2514 Hamilton Ave.

Filed MAY 1 1929, 19 C. HAMPSON JONES, Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Nov. 28 1929

17 I HEREBY CERTIFY, That I attended deceased from April 23, 1929, to April 28, 1929, that I last saw him alive on April 28, 1929, and that death occurred, on the date stated above, at 11:00 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Uremia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. L. Snyder M. D.

4/29, 1929 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross A. A. Co. DATE OF BURIAL: May 1, 1929

20 UNDERTAKER: Margaret E. Flynn ADDRESS: 1422 Light St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45563

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45563

CERTIFICATE OF DEATH

× 74-001

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 106 N Amity ST. 18-16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Hannah F. Houston

(a) RESIDENCE NO. 106 N. Amity ST., WARD 9. C.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Col.	Wid

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Orange Houston

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Vecona N.C.

PARENTS

10 NAME OF FATHER Calvin Boone

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Tenia ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Callie Robinson

(Address) 106 N Amity St

15 Filed MAY 1 1929 HAMILTON JONES, Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30/29

17 I HEREBY CERTIFY, That I attended deceased from April 25, 1929, to April 30, 1929, that I last saw h alive on April 30, 1929 and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Pulmo Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Howard, M. D.

May 1st, 1929 (Address) 939 N Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	May 2, 1929
20 UNDERTAKER	ADDRESS 322 S.
Mrs. Katie R. Williams	Schroeder St.

Be brief in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec. 1-12-23—M&T—500 Bks.

E 45564 HEALTH DEPARTMENT—CITY OF BALTIMORE E 45564

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3319 Spaulding St. 27-5 90 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Woodhouse

(a) RESIDENCE NO. 3319 Spaulding Ave. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, ~~Widowed, or divorced~~ HUSBAND of (or) WIFE of: James H. Woodhouse

6 DATE OF BIRTH (month, day, and year): Nov 26-1859

7 AGE — Years: 69 — Months: 5 — Days: 4 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Henry Evans

11 BIRTHPLACE OF FATHER (city or town) (State or country): Cardiff Wales

12 MAIDEN NAME OF MOTHER: Catherine Phelps

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Cardiff Wales

14 Informant (Address): James H. Woodhouse 3319 Spaulding Ave

15 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 30 1929

17 I HEREBY CERTIFY, That I attended deceased from Apr 3rd, 1929, to April 30, 1929, that I last saw h[illegible] alive on Apr. 30, 1929 and that death occurred, on the date stated above, at 2.15 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) James H. Brown, M. D.

1929 (Address) 1837 Penna Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet

DATE OF BURIAL: Fri 3 1929

20 UNDERTAKER: Geo. W. Little

ADDRESS: 2200 Edmondson

MAY 1 - 1929

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 45565

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45565

CERTIFICATE OF DEATH.

161-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1029 Race ST. 22-31 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME (Premature) Dancy -

(a) RESIDENCE NO. 1029 Race ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): 4/29/29

7 AGE: Years — Months — Days — If LESS than 1 day 16 hrs. or — min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER William Dancy

11 BIRTHPLACE OF FATHER (city or town) Barbour (State or country) N. Carolina

12 MAIDEN NAME OF MOTHER Stella Bridges

13 BIRTHPLACE OF MOTHER (city or town) Wilkes (State or country) N. Carolina

14 Informant: William Dancy (Address) 1029 Race

15 1-1929 C. HAMPSON JONES, M. D. Registrar

3528

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 30 1929

17 I HEREBY CERTIFY, That I attended deceased from 4/29, 1929, to 4/30, 1929, that I last saw h alive on 4/30, 1929, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Premature

6 hrs -

Pregnancy -

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Maternal Death

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? None

(Signed) Dan Francken M. D.

4/30 1929 (Address) 122 W Mt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER: Commissioner Health

ADDRESS MAY 1 192

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

JARBOE, V

E 45566

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45566

CERTIFICATE OF DEATH

86-002

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1214 Eutaw Place (ST.) Baltimore Eye Hosp (WARD) 27-5

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katherine Fryfogle Jarboe

(a) RESIDENCE. NO. 4014 Primrose, Arlington ST.. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 16 yrs 2 mos. 17 ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harold E. Jarboe

6 DATE OF BIRTH (month, day, and year) Feb. 12 - 1913

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	16	2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wm E. Fryfogle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Co. Md

12 MAIDEN NAME OF MOTHER Nellie V. Constantine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Harold E. Jarboe

(Address) 4014 Primrose Ave

15 Filed MAY 1-1929 C. HAMPSON JONES, M. D. Registrar

Per MKK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb. 28, 1929, to April 29, 1929, that I last saw her alive on April 29, 1929, and that death occurred, on the date stated above, at 2:30 P. m.

The CAUSE OF DEATH* was as follows:

Septicemia

(duration) yrs. mos. 49 ds.

CONTRIBUTORY (Secondary) Double mastoiditis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? yes Date of 3/14/29

Was there an autopsy? no

What test confirmed diagnosis? Blood cultures

(Signed) Jesse Wenner Jr. M. D.

, 19 (Address) 529 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Mt. Olive (Roslyn, Baltimore) May 2, 1929

20 UNDERTAKER — ADDRESS

Horace F. Burgee 1631 Fulton Ave

MATTER should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45567

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45567

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 518 E. Thirty fifth St., 9-4 WARD)

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME May Magliditt

(a) RESIDENCE NO. 518 E. Thirty fifth ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William P. Magliditt

6 DATE OF BIRTH (month, day, and year) May 8 1880

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
48	11	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Co. Maryland

PARENTS

10 NAME OF FATHER Benjamin F. Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Co. Maryland

12 MAIDEN NAME OF MOTHER Jennie Amos

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Co. Maryland

14 Informant William P. Magliditt
(Address) 518 E. Thirty fifth

15 Filed MAY 1 1929, 19 C. HAMPSON JONES, M. D. Registrar
Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1st

17 I HEREBY CERTIFY, That I attended deceased from May 1924 to May 1 1929, that I last saw her alive on May 1 1929 and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 5 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? At place of death.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wilbur S. Fuller, M. D.

4-30, 1929 (Address) 43 E. Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	May 4 1929
20 UNDERTAKER	ADDRESS
Frederick Lassahn	Fairfield

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45568

CERTIFICATE OF DEATH

13 E 45568

1—PLACE OF DEATH Union Mem Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 14-21 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Dared Shelton Lee Thompson

(a) RESIDENCE NO. 1732 West Fayette ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) 12-19-28

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Shelton Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Nettie Walker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records
(Address)

15 Filed ..., 19... C. HAMPSON JONES, M. D. Registrar

1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-1-29

17 I HEREBY CERTIFY, That I attended deceased from 1-28, 1929, to 5-1, 1929, that I last saw him alive on 5-1, 1929, and that death occurred, on the date stated above, at 7 0 m.

The CAUSE OF DEATH* was as follows:

Diarrhea & Enteritis (under 3 yrs)

(duration) yrs. 4 mos. 1 ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. 4 mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? clinical findings

(Signed) Wallace R Swartzwelder, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 5 3 1929

20 UNDERTAKER H. W. Cook

ADDRESS 217 St Paul St

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 45569 HEALTH DEPARTMENT—CITY OF BALTIMORE E 45569

CERTIFICATE OF DEATH

1—PLACE OF DEATH REGISTERED NO. 8017

CITY OF BALTIMORE: (No. St. Joseph's Hosp ST., (or) WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry Rockelman

(a) RESIDENCE NO. 1721 North Wolfe ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Jan 21. 1878

7 AGE: Years 51 | Months 3 | Days 10 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Engineer

(b) General nature of industry, business, or establishment in which employed (or employer): R.R.

(c) Name of employer: United R.R.

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Mathias Rockelman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Louise Bentze

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs L. H. Clark

(Address) 2647 W Garden St

15 C. HAMPSON JONES, M. D. Registrar

5-1-1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 1-1929

17 I HEREBY CERTIFY, That I attended deceased from Apr. 27, 1929, to May 1, 1929, that I last saw him alive on May 1, 1929 and that death occurred, on the date stated above, at 4 45 a m.

The CAUSE OF DEATH* was as follows:

Chronic Thyocarditis

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) acute Cardiac Dilatation (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes Clinical

What test confirmed diagnosis?

(Signed) A. Lupton, M. D.

5/1, 1929 (Address) St Josephs Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore — DATE OF BURIAL 5 4 1929

20 UNDERTAKER: W M Cohn — ADDRESS 1217 E Baltimore St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45570

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45570

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital 9-45 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME DAVID KENTON

(a) RESIDENCE NO. Easton, Md — ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 18 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 30, 1926

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Easton Md —

PARENTS

10 NAME OF FATHER Gilda B. Kenton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Delaware

12 MAIDEN NAME OF MOTHER Edith Livesaye

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Gilda B. Kenton

(Address) Easton, Md —

15 Filed 1929 C. HAMPSON JONES, M. D. Registrar

Per AKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 17, 1929, to April 30, 1929, that I last saw h— alive on April 30, 1929 and that death occurred, on the date stated above, at 5 05 P. M.

The CAUSE OF DEATH* was as follows:

Simple Encephalitis

(duration) yrs. mos. 18 ds.

CONTRIBUTORY (Secondary) Left Otitis Media

(duration) yrs. mos. 13 ds.

18 Where was disease contracted if not at place of death? Easton, Md

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Addison Craft Stein, M. D.

4-30 1929 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greensboro. Md

DATE OF BURIAL 5/1 1929

20 UNDERTAKER J. M. Cook

ADDRESS 1217 E Pratt St

1 - 1929

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 45571

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45571

CERTIFICATE OF DEATH.

1-PLACE OF DEATH West Balto Gen Hospt

CITY OF BALTIMORE, (No.) Raynor & Dulaney ST., (WARD) 16

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edith Anna Sommers

(a) RESIDENCE No. 504 N. Caloski ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 29 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female

4 COLOR OR RACE white

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 4-27-29

7 AGE — Years: ..... Months: ..... Days: 4 — If LESS than 1 day, hrs. or min.: 3 days

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) Balto. Md (State or country)

PARENTS

10 NAME OF FATHER John Sommers

11 BIRTHPLACE OF FATHER (city or town) Pa. (State or country)

12 MAIDEN NAME OF MOTHER Edith Koller

13 BIRTHPLACE OF MOTHER (city or town) Balto Md (State or country)

14 Informant John Sommers (Address) 504 N Caloski St

15 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5 1 1929

17 I HEREBY CERTIFY, That I attended deceased from 4 27, 1929 to 6 1, 1929 that I last saw h[er] alive on 5 1, 1929 and that death occurred, on the date stated above, at 6.35 a m.

The CAUSE OF DEATH* was as follows:

1 Intra cranial hemorrhage

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Spinal puncture

(Signed) Dr J Thomas Fulton, M. D.

, 19 (Address) 1001 N Fulton ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet — DATE OF BURIAL 5 2 1929

20 UNDERTAKER H. M. Cook — ADDRESS 121 N Carey

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-1929

Spec.—2-29-28—L. F. S.—500 Bks.

E 45572

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45572

CERTIFICATE OF DEATH

31

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

CITY OF BALTIMORE: (No. [redacted] ST., 3-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Franklin

(a) RESIDENCE NO. 228 S. Dallas ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Franklin

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
60				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records of

(Address) BALTIMORE CITY H[illegible]

15 Filed MAY 1 1929, 19 C. THAMPSON JONES, M. D.

By Acct Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 28, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 18, 1929, to April 28, 1929, that I last saw him alive on April 28, 1929 and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis.

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. M. Stark, M. D.

, 19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woburn Cemetery

DATE OF BURIAL 5/2/29 19

20 UNDERTAKER Geo J Kuth

ADDRESS 1735 Harford Av.

IMPORTANT. See instructions on back of certificates. Exact statement of OCCUPATION is very important. See instructions on back of certificates. DEATH in plain terms, so that it may be properly classified.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45573

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 45573

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1213 Eutaw Place ST. 1774 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Miss Marie Anna Mendel

(a) RESIDENCE NO. 1213 Eutaw Place ST., WARD 7th
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 10 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) October 19, 1874

7 AGE	Years	Months	Days	If LESS than 1 day 12 hrs. or min.
	54	6	10	

8 OCCUPATION OF DECEASED None.

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Brooklyn
(State or country) New York.

PARENTS

10 NAME OF FATHER Peter John Mendel

11 BIRTHPLACE OF FATHER (city or town) Wiesbaden
(State or country) Germany.

12 MAIDEN NAME OF MOTHER Louisa Feix

13 BIRTHPLACE OF MOTHER (city or town) Walsdorf
(State or country) Germany.

14 Informant Miss Elise Mendel (sister)

(Address) 1213 Eutaw Place.

15 Filed MAY 1 1929, 19 [illegible]
(Registrar)

WILLIAMSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30, 1929.

17 I HEREBY CERTIFY, That I attended deceased from June 28, 1929, to April 30, 1929, that I last saw h[illegible] alive on April 29, 1929 and that death occurred, on the date stated above, at 12.50 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
(Hypertensive cardiovascular
renal disease

(duration) 15 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Brooklyn, N. Y.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Morris Harold Goodman, M. D.

19 (Address) 2442 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem.	May 2 1929
20 UNDERTAKER	ADDRESS
Wm. L. Black	927 N. Broadway

Y 1-1929

important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45574

CERTIFICATE OF DEATH.

E 45574

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 3526 Old ~~Frederick~~ Frederick Rd St, 2040 Ward)

2-FULL NAME Rosa A. Schubert

(a) RESIDENCE NO. 3526 Old ~~Frederick~~ Frederick Rd St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: W. A. Schubert

6 DATE OF BIRTH (month, day, and year): July 15 1864

7 AGE: Years 64 Months 9 Days 12 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED: W. W.

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md

PARENTS

10 NAME OF FATHER Wm. J. Pierpont

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Stevens

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Laura Schubert

(Address) 3526 Old ~~Frederick~~ Frederick Rd.

15 Filed _____, 19____ HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 30 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

a) Senility

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) Chas. H. Brooke M. D. (Coroner)

4/30 1929 (Address) Broadway Dispensary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery Date of Burial May 3rd 1929

20 UNDERTAKER: F. B. Wehrfurt ADDRESS 1850 W. Balto St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Y 1-1929

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45575 88 E 45575

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. [illegible] ST., 7-10 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Russell Styles (Stiles)

(a) RESIDENCE NO. 1508 Milliman ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. ... mos. ... ds. How long in U. S., if foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	19			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 640

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George Styles

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Henrietta Mortimer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Records of

(Address)

15 Filed ..., 19... C. HAMPSON JONES, M. D.

Per ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 26, 19 29, to April 30, 19 29,

that I last saw him alive on April 30, 19 29

and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Subacute Bacterial Endocarditis

(duration) ... yrs. 2 mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? R. Autopsy

(Signed) R. M. Wish, M. D.

..., 19... (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cambridge Md	5-2 1929
20 UNDERTAKER	ADDRESS
Jas. M. Skinner	1625 E. Mad st

Y 1-1929

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45576

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45576

CERTIFICATE OF DEATH

58-001

1—PLACE OF DEATH

REGISTERED NO. 28-63

CITY OF BALTIMORE: (No. Mt Hope Retreat ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary R. Anderson

(a) RESIDENCE NO. Mt Hope Retreat ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. 3 mos. 14 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Dec 23 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	39	4	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): New York, New York

PARENTS

10 NAME OF FATHER: Jno. H. Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Cranbury, New Jersey

12 MAIDEN NAME OF MOTHER: Mary Flannigan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Brooklyn, New York

14 Informant: Mrs H. H. Reeves

(Address): Mt Hope Retreat

15 Filed ..... 1929, 19..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 1. 1929

17

I HEREBY CERTIFY, That I attended deceased from Aug 1, 1924, to May 1, 1929,

that I last saw h[illegible] alive on May 1, 1929

and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH was as follows:

Pernicious Anaemia

(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Epilepsy

(duration) 14? yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Tuberculin

(Signed) Walter P. Bell, M. D.

. 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Flushing L. I.	May 3 1929
20 UNDERTAKER: Stewart & Monroe	ADDRESS: Baltimore

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45577 HEALTH DEPARTMENT—CITY OF BALTIMORE E 45577

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 9

CITY OF BALTIMORE: (No. University Hosp. ST. 18-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Beatrice Thornton

(a) RESIDENCE NO. 16 S. Carlton ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

6 DATE OF BIRTH (month, day, and year): April - 1928

7 AGE — Years: 1 — Months: 1 — Days: — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Beverly Thornton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Elizabeth Whitney

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Ashley Thornton

(Address) 16 S. Carlton Ave

15 [illegible] JONES, M. D. Registrar

5 - 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/1/29

17

I HEREBY CERTIFY, That I attended deceased from 4/24/29, to 5/1/29

that I last saw her alive on 5/1, 1929

and that death occurred, on the date stated above, at 130 P. m.

The CAUSE OF DEATH* was as follows:

Pertussis

Broncho-pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Harry Hamburg, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem

DATE OF BURIAL: 5/2 19 29

20 UNDERTAKER: Samuel Wemsley

ADDRESS: N Bdle

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 45578

CERTIFICATE OF DEATH.

E 45578

1-PLACE OF DEATH Franklin Square Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Calhoun & Fayette ST. 21-24 WARD)

2-FULL NAME Mary Fitzsimmons

(a) RESIDENCE NO. 703 W. Barre ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	widowed

3a If married, widowed, or divorced HUSBAND of (or) WIFE of not known

6 DATE OF BIRTH (month, day, and year) " "

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Jos. H. Burkeene (Address) 2108 Smith ave

15 Filed 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 1929

17 I HEREBY CERTIFY, That I attended deceased from April 26. 1929. to May 1 1929.

that I last saw her alive on May 1 1929,

and that death occurred, on the date stated above, at 5:50 P. m.

The CAUSE OF DEATH* was as follows:

Broncho - pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Elizabeth B. Sherman M. D.

5/1 1929 (Address) Franklin Square Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL 4-3 1929

20 UNDERTAKER Bernard C Hart — ADDRESS 1000 S Paca St

MAY 2-1929 Per

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 45579 HEALTH DEPARTMENT—CITY OF BALTIMORE **E 45579**

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 720 N. Appleton St. 16-22 Ward) 129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Minnie Annie Booth.

(a) RESIDENCE NO. 720 N Appleton St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
female	white	widowed.

5a If married, widowed, or divorced ~~HUSBAND OF~~ (or) WIFE of John T. Booth

6 DATE OF BIRTH (month, day, and year) July 10-1856

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	72	9	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland.

PARENTS

10 NAME OF FATHER John A. G. Goetz

11 BIRTHPLACE OF FATHER (city or town) —

(State or country) Germany.

12 MAIDEN NAME OF MOTHER Margaret Lenderman

13 BIRTHPLACE OF MOTHER (city or town) —

(State or country) Germany.

14 Informant Percy L. Booth

(Address) 720 N. Appleton St.

15 C. HAMPSON JONES, M. D. Registrar.

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 1929

17 I HEREBY CERTIFY, That I attended deceased from 4-23- 1929, to 5-1- 1929, that I last saw h.. alive on 4-30- 1929, and that death occurred, on the date stated above, at 2:45 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Organic Heart disease

(duration) unknown yrs. mos. ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Urinalysis & physical Signs

(Signed) Chester Ruland, M. D.

5-1-. 1929 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Date of Burial May 3 1929

20 UNDERTAKER Wm J. Pickett Sons ADDRESS N. Y. Ave

Y 2-1929

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45580

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 45580

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 13-54

CITY OF BALTIMORE: (No. 2301 Eutaw Place WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Flora Oppenheimer

(a) RESIDENCE NO. 2301 Eutaw Place ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life time How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Leon Schwab

6 DATE OF BIRTH (month, day, and year) Sept. 17 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60	7	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Reuben Oppenheimer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Julia Weinberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. C. Oppenheimer (Address) 2301 Eutaw Place

15 MAY 2 - 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30, 1929.

17 I HEREBY CERTIFY, That I attended deceased from July 17, 1928, to April 30, 1929, that I last saw h.. alive on April 30, 1929 and that death occurred, on the date stated above, at 1.15 P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) — yrs. — mos. 10 ds.

CONTRIBUTORY (Secondary) Paget's Disease (Osteitis deformans)

(duration) 33 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Louis P. Hamburger, M. D.

, 19 (Address) 1207 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Har Sinai Cem	May 2 1929
20 UNDERTAKER	ADDRESS
David Sonnheim Royal Co	1124 Mt.

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

George N. Schaefer, Sr.

E 45581

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45581

CERTIFICATE OF DEATH

101-00

1—PLACE OF DEATH

REGISTERED NO. 14-29

CITY OF BALTIMORE: (No. 911 Hollins St. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George N. Schaefer Sr.

(a) RESIDENCE NO. 911 Hollins St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie Schulz Schaefer

6 DATE OF BIRTH (month, day, and year) Jan 17, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	3	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John Schaefer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Carrie Schaefer

(Address) 911 Hollins St.

15 Filed MAY 2 - 1929 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 26, 1929, to April 30, 1929, that I last saw h im alive on April 30, 1929 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pneumonia(lober)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw Hanselmann, M. D.

5/1, 1929 (Address) 24 W. Fallis Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	May 4, 1929
UNDERTAKER J. F. Cowen & Son	ADDRESS 902 Hollins St.

important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 45582

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 45582

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3601 Keene ave (Hamilton) ST. 27-43 WARD

2-FULL NAME Katie F. Parrott

(a) RESIDENCE NO. 3601 Keene ave ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 72 yrs. 10 mos. 28 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of: John E. Parrott

6 DATE OF BIRTH (month, day, and year): June 1st 1856

7 AGE — Years: 72 — Months: 10 — Days: 28 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: William Heise

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary Lenz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: William Parrott
(Address) 3601 Keene ave

15 Filed MAY 2 - 1929 19 C. HAMPSON JONES, M.D.
By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Apr 29 1929

17 I HEREBY CERTIFY, That I attended deceased from 1/1/1926, 19 ... to 4/29 1929, that I last saw h[illegible] alive on 4/26/29, 19 ... and that death occurred, on the date stated above, at 12.27 P.M. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary): Pneumonia

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. Frank Gray, M. D.

4/30 19 29 (Address) 2939 McElderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Hamilton — DATE OF BURIAL: 5/2/1929

20 UNDERTAKER: [illegible] Wilson & Son — ADDRESS: 2473 Edmondson Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45583

CERTIFICATE OF DEATH

21 ~ E 45583

1—PLACE OF DEATH

REGISTERED NO. 1359

CITY OF BALTIMORE: (No.) Baltimore City Hospitals ST., (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Benjamin Littlejohn

(a) RESIDENCE NO. 2508 Madison ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Robert Littlejohn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Bettie Burrell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Hospital Records
(Address)

15 Filed MAY 2 1929, 19 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30, 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb. 1, 1929, to April 30, 1929,

that I last saw him alive on April 30, 1929

and that death occurred, on the date stated above, at 6 p. m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary tuberculosis

(duration) About 4 mos. ds.

CONTRIBUTORY (Secondary) Hydropneumothorax

(duration) About 4 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis Clinical and autopsy

(Signed) Henry C. Smith, M. D.

4-30-1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	5/2/1929
20 UNDERTAKER	ADDRESS
Mrs. Geo. H. Holland	1631 Druid

important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45584

CERTIFICATE OF DEATH.

E 45584

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Charles & Maryland St. 11-9-4 Ward)

2-FULL NAME Charles Boston

(a) RESIDENCE NO. 1124 Bresard St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: C

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ida Boston

6 DATE OF BIRTH (month, day, and year): 3-17-77

7 AGE: Years 52 Months 1 Days 13 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Porter 070

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country): Md

PARENTS

10 NAME OF FATHER: W. Boston

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Md

12 MAIDEN NAME OF MOTHER: Laura Turner

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Md

14 Informant: Rose Brewington

(Address) 1124 Bresard St

15 Filed MAY 2 - 1929 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/30 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquest.) thereon and from the evidence obtained by said Inquest (Coroner's inquest, autopsy or inquest.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) John Thomsen M. D. (Coroner)

5/1, 1929 (Address) 1362 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary Cem. Date of Burial May 2 1929

20 UNDERTAKER: Wm. R. G. Elliott ADDRESS 712 Eastland Ave

Don should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Bks.

E 45585

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

CERTIFICATE OF DEATH

E 45585
REGISTERED NO.

1-PLACE OF DEATH Aged Women Home

City of BALTIMORE: (No. 1404 W Lexington St. 19-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice V Griffin

(a) RESIDENCE NO. 1404 W Lexington St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec 5, 1857

7 AGE — Years: 71 Months: 4 Days: 26 IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Martha E Wilkes

(Address) 1404 W Lexington

Filed MAY 2-1929. C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 1, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 29, 1929, to May 1, 1929, that I last saw h[illegible] alive on April 29, 1929, and that death occurred, on the date stated above, at 7:45A.m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) ....yrs. ....mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edwin A Jarrell, M. D.

, 19 (Address) 1115 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Olivet — Date of Burial: May 3 1929

20 UNDERTAKER: George J Smith — ADDRESS 1532 Harlem

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45586

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 45586

1—PLACE OF DEATH

REGISTERED NO. 9-46

CITY OF BALTIMORE: (No. 2718 Hugo Ave. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Christina C. Seebach

(a) RESIDENCE NO. 2718 Hugo Ave. ST. 9 WARD
(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. 5 mos. 13 ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas. J. Seebach

6 DATE OF BIRTH (month, day, and year) Nov. 18th 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38	5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Leo Rietzing

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Goos.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Charles J. Seebach.

(Address) 2718 Hugo Ave.

15 Filed MAY 2-1929, 19 [illegible] Registrar

HAMPSON JONES, M. D.

important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1st 1929

17 I HEREBY CERTIFY, That I attended deceased from May, 1925, to May 1st, 1929, that I last saw her alive on May 1st, 1929, and that death occurred, on the date stated above, at 2 20 P. m.

The CAUSE OF DEATH* was as follows:

Organic heart disease

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Frits J. Linzer M. D.

5/1, 1929 (Address) 2700 Hoffman St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	May 4 1929
20 UNDERTAKER	ADDRESS
Lilly & Gaither Co.	409 S. Hoyt St.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45587

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45587

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 27-48

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 5713 Ballona ave. ST. WARD)

2—FULL NAME George Whitman Roche

(a) RESIDENCE NO. 5713 Ballona ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 3 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma E Roche

6 DATE OF BIRTH (month, day, and year) Aug. 29 1875

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
53	9	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stationary Fireman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto County (State or country) Maryland

PARENTS

10 NAME OF FATHER William Roche

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto County Md

12 MAIDEN NAME OF MOTHER Margaret Jane Wright

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto County Md

14 Informant Mrs Paul J Alam

(Address) 5713 Ballona Ave

15 Filed MAY 2 1929 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 29

17 I HEREBY CERTIFY, That I attended deceased from 4-2-29, to 5-1-29, that I last saw h alive on 5-1-29 and that death occurred, on the date stated above, at 2.30 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) yrs. 1/2 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of 4-20-29

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) Paul J Alam M. D.

(Address) 500 N Rolling Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemtery — DATE OF BURIAL May 4 1929

20 UNDERTAKER Howard K Malcom — ADDRESS Irvington Md

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

45588 — CERTIFICATE OF DEATH — 43 — E 45588

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. [illegible] ST. [illegible] WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rose Benen

(a) RESIDENCE NO. 942 Leadenhall ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1884

7 AGE — Years: 47 — Months: — Days: — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Launches

(b) General nature of industry, business, or establishment in which employed (or employer): [illegible]

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Armstead Holmes

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Mary Roberts

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Edna Thomas

(Address): 707 Sharp

15 Filed: 2 1929 Registrar

C. H. WILLIAMSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 4/30/29

17 I HEREBY CERTIFY, That I attended deceased from 12/27, 1928, to 4/30, 1929, that I last saw h[illegible] alive on 4/30, 1929, and that death occurred, on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Pneumonia

Lobar

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Findings

(Signed) T. M. Hock, M. D.

, 19 (Address) Balt & Guilford

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: [illegible] — DATE OF BURIAL: May 3 1929

20 UNDERTAKER: [illegible] — ADDRESS: [illegible]

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 45589

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45589

CERTIFICATE OF DEATH

74-001

1-PLACE OF DEATH

City of Baltimore: (No.) 3015 Wayne Ave (St.) 28-64 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm Snyder

(a) RESIDENCE NO. 3015 Wayne Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frances Snyder

6 DATE OF BIRTH (month, day, and year): Aug 15 - 1850

7 AGE: Years 78 | Months 8 | Days 14 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Clerk
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer: Mathias Ingram

9 BIRTHPLACE (city or town): Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER: [illegible]

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant: Frances Snyder
(Address) 3015 Wayne Ave

15 C. HAMPSON JONES, M. D.
Registrar

2 - 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): May 1 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(Antecedent) (duration) Sudden yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) F. Schunk, M. D.

May 2nd 1929 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: May 4 1929

20 UNDERTAKER: Harry N. Armagost & Co. — ADDRESS: 4264 Ridgewood Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45590 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45590

CERTIFICATE OF DEATH

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST., 3 B. 4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Olacywski (Olszewski)

(a) RESIDENCE NO. 605 S. Bond st. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? Unknown yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Olszewski

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown Mikolaj Olszewski

11 BIRTHPLACE OF FATHER (city or town) Poland (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown Bathina Gajewski

13 BIRTHPLACE OF MOTHER (city or town) Poland (State or country) Poland

14 Informant Hospital Records

(Address)

15 C. HAMPSON JONES, M. D. Registrar

2-1929 Mar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 3, 1928, to May 1, 1929, that I last saw him alive on May 1, 1929 and that death occurred, on the date stated above, at 7.05 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical and lab.

(Signed) Henry C. Smith M. D.

5-1, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	May 7 1929
20 UNDERTAKER	ADDRESS
John M. Wilbert's	Chester

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45591

CERTIFICATE OF DEATH

E 45591

44

8-45

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2736 Pelham Ave. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME S. KATHERINE RAY

(a) RESIDENCE NO. 2736 Pelham Ave. ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

.a If married, widowed, or divorced HUSBAND of (or) WIFE of — — —

6 DATE OF BIRTH (month, day, and year) August 12, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	8	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Edward Ray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Jefferson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Jennie Nies (Sister)

(Address) Taylor & Victory Aves. Parkville

15 C. HAMPSON JONES, M. D. Registrar

5-2-1929 Per ACH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30, 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb 1 28 1929 to April 30, 1929 that I last saw her alive on April 30 1929 and that death occurred, on the date stated above, at 10.10 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Liver

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Gustave Ratt, M. D.

5/1 1929 (Address) Overlea, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Spring Hill Cemetery Easton MD	May 3 1929

20 UNDERTAKER Henry Sander & Sons. Inc.

ADDRESS BALTIMORE ST. & BROADWAY.

important. See instructions on back of certificates.

Spec. –7-17-26—A Co.—200 Bks.

E 45592

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 45592

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Md. Gen. Hosp. St. 20-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theodore E. Hoeschath

(a) RESIDENCE NO. 59 Culver St St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S. if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of: mrs Hoeschath

6 DATE OF BIRTH (month, day, and year): Jan 4, 1874

7 AGE: Years 55 Months 4 Days 3

IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cabinet maker

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Germany

PARENTS

10 NAME OF FATHER: Theodore

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Marie Wagner

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14 Informant: Mrs. Laura

(Address)

15 Filed 5-2-1929 C. HAMPSON JONES, M. D. Registrar

By AKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5-2 1929

17 I HEREBY CERTIFY, That I attended deceased from 4-30-, 1924, to 5-2-, 1929.

that I last saw him alive on 5-2-, 1929.

and that death occurred, on the date stated above, at 6.15 A.m.

The CAUSE OF DEATH* was as follows:

Aortic valvular insufficiency with active failure. (Cardio Vascular.)

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary): Pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory

(Signed) [illegible] M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. Date of Burial May 4, 1929.

20 UNDERTAKER: Randall J. Hyppel ADDRESS 3008 Eden

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45593

CERTIFICATE OF DEATH

117 E 45593

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Saint Josephs Hospital ST. 8th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Preisinger

(a) RESIDENCE NO. 2419 Llewelyn Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Leah Preisinger

6 DATE OF BIRTH (month, day, and year) 11 27 1902

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
26	5	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Henry Preisinger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Herold

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Amelia Schwabenberg

(Address) 2419 Llewlyn Avenue

15 Filed MAY 3-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/2/29

17

I HEREBY CERTIFY, That I attended deceased from 4/24, 1929, to 5/2, 1929, that I last saw him alive on 5/2, 1929 and that death occurred, on the date stated above, at 8:45 A m.

The CAUSE OF DEATH* was as follows:

Appendicitis

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? yes Date of 4/24/29

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. C. Zimmerman, M. D.

, 19 (Address) St. Josephs Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL 5 6 1929

20 UNDERTAKER Albert L Hilty

ADDRESS 1606 N Charles St

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45594 129 **E 45594**

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) 6 W. Kenwood ave (ST.) 6 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Winnefred Walsh

(a) RESIDENCE NO. 6 W. Kenwood ave ST. 6 WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F. | 4 COLOR OR RACE W | 5 Single, Married, Widowed, or Divorced (write the word) Widow

a If married, widowed, or ~~divorced~~ ~~HUSBAND of~~ (or) WIFE of Wm. J. Walsh

6 DATE OF BIRTH (month, day, and year) Nov. 11 1876

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
53	5	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John Murphy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ire

12 MAIDEN NAME OF MOTHER Kathy Scally

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Kate Murphy (Address) 6 W. Kenwood ave

15 Filed C. HANSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH 4-30 29

16 DATE OF DEATH (month, day, and year) 4-30-29

17 I HEREBY CERTIFY, That I attended deceased from 4-21 1929 to 4-30 1929 that I last saw her alive on 4-30 1929 and that death occurred, on the date stated above, at 1.30 A m.

The CAUSE OF DEATH* was as follows:

Myocardial Degeneration

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Intestinal Nephritis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) D. and Miller M. D.

4/30 1929 (Address) 1500 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem. | DATE OF BURIAL May 3, 1929

20 UNDERTAKER J. A. Moran | ADDRESS 3100 Balto

Important. See instructions on back of certificates.

MAY 2-1929

Spec.—2-29-28—L. F. S.—500 Rks.

Anna Donulkewicz

E 45595

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 45595

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hosp.

REGISTERED NO.

CITY OF BALTIMORE: (No. (Donulkewicz) 173-3) ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna Donulkewicz

(a) RESIDENCE NO. 27 W. West ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if foreign birth? 19 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Tony Danielkiereizz

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Ignatz Bedurgick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Afemia ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Records of

(Address) Baltimore City Hosps.

15 Filed MAY 3-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 29, 19 29, to May 1, 19 29, that I last saw her alive on May 1, 19 29 and that death occurred, on the date stated above, at 7:10 A m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia, bilateral

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? R Typical Lobar Pneumonia

(Signed) H. M. Hack, M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Russian Independent	May 4, 1929

20 UNDERTAKER John Grebliauckas ADDRESS 423 S Paca St.

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45596

CERTIFICATE OF DEATH

38 E 45596

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore Ave 1921-23 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Geo Fotwell

(a) RESIDENCE NO. 1571 Ridgley ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Mal	Wh to	Marrid

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lila Fotwell

6 DATE OF BIRTH (month, day, and year) Dec 31, 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	4	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Geo Fotwell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Lizzie Cotrey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Lila Fotwell

(Address) 1571 Ridgley Ave

15 Filed MAY 3 - 1929 19

C. HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/2/29

17 I HEREBY CERTIFY, That I attended deceased from 3/31, 19 29, to 5/2, 19 29, that I last saw h— alive on 5/2, 19 29 and that death occurred, on the date stated above, at 7.30 m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar
Left Knee

Inf (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronch Pneu

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Hm

Did an operation precede death? Yes Date of 4/3/29

Was there an autopsy? Yes Authorities

What test confirmed diagnosis? Clinical

(Signed) H. M. Hoch, M. D.

19 (Address) Balto City Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Michaels Md — DATE OF BURIAL: 5/6 19 29

20 UNDERTAKER J. M. Cook — ADDRESS 1212 Pont St

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

Dr Sellmer, Coroner's Physician

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45597

CERTIFICATE OF DEATH

E 45597

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) 919 N. Eden ST. 10-13 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William J. Doyle

(a) RESIDENCE NO. 919 N. Eden ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. 6 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Emma M. Doyle

6 DATE OF BIRTH (month, day, and year): Oct 19, 1865

7 AGE — Years: 63 | Months: 6 | Days: 12 | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Horse shoer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: U. A. & C. Co.

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs Emma Doyle

(Address) 919 N. Eden St

15 Filed MAY 3 - 1929 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 1, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 29, 1929, to May 1st, 1929, that I last saw h[illegible] alive on April 30th, 1929, and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): Coma

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) S. Sellmer M. D.

May 1st, 1929 (Address) 201 N. Eden St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge

DATE OF BURIAL: 5 3 1929

20 UNDERTAKER: J. M. Cook

ADDRESS: 219 N. Gay St

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45598

CERTIFICATE OF DEATH

31

E 45598

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Baltimore City Hospitals (ST.) (WARD) 9-1-31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Siemon

(a) RESIDENCE NO. 923 S. Fremont ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Siemon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Susan Schmidt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Records

(Address)

15 MAY 3 - 1929 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 13, 1929, to April 30, 1929, that I last saw him alive on April 30, 1929 and that death occurred, on the date stated above, at 6 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical and Lab.

(Signed) Danny Smith, M. D.

4-30, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	May 3 1929
UNDERTAKER M. D. John F. Denny	ADDRESS 715 Light St

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45599 CERTIFICATE OF DEATH E 45599

REGISTERED NO. 100-091

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William T Watts

(a) RESIDENCE NO. Glenburnie Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Lydia E Watts

6 DATE OF BIRTH (month, day, and year) April 4 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	—	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Farmer

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) Glenburnie A A Co Md

10 NAME OF FATHER William T Watts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Glenburnie Md

12 MAIDEN NAME OF MOTHER Julia Watts

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Glenburnie Md

14 Informant Mrs Lydia E Watts

(Address) Glenburnie Md

15 Filed MAY 3-1929 G. HARRISON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 27, 1929, to May 2, 1929, that I last saw h[illegible] alive on May 2 1929 and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Hypertrophied Prostate

Cystitis

Myocardial Degeneration

(duration) yrs. mos. 2 1 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry Vincent Davis, M. D.

5-2, 1929 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pinehcomb Home Cemetery	May 5 1929
20 UNDERTAKER D. John F Denny	ADDRESS 715 L & W St

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45600

CERTIFICATE OF DEATH

44

REGISTERED NO. E 45600

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2022 E. Fayette ST. 6-9 WARD)

2—FULL NAME Katherine Mary Jones

(a) RESIDENCE NO. 2022 E. Fayette ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If ~~married, widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of August Jones

6 DATE OF BIRTH (month, day, and year) Dec 15 - 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58	4	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 039

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Wm Wallbaker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Justina Bach

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hilda Jones
(Address) 2022 E Fayette

15 Filed 2-1929 C. HAMPSON JONES, M. D. Registrar
By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 - 1929

17 I HEREBY CERTIFY, That I attended deceased from March 24, 1929, to May 1, 1929, that I last saw h.e alive on 5-1 1929 and that death occurred, on the date stated above, at 4.15 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach & Intestines

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Toxic absorption

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? —

What test confirmed diagnosis? X Ray

(Signed) Edward Lewis, M. D.

5/1, 1929 (Address) 413 N Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	May 4 1929
20 UNDERTAKER	ADDRESS
Jos. J. Kerr	1504 Luzerne

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 45601

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1007

186 E 45601

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2224 Ethney St. 14-59 Ward)

2-FULL NAME Henry Williams

(a) RESIDENCE NO. 2224 Ethney St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of forcign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lonie Williams

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	68			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Mobile Ala
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Lana Connor
(Address) 2224 Ethney

15 Filed ..... 19 .....

C. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 30 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Motorcycle accident.

Lobar Pneumonia.

CONTRIBUTORY (Secondary) Amputation of Leg (duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted? If not at place of death? Together near Spring

Did an operation precede death? Yes Date of April 28

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) Wm. H. McQuirk M. D.

(Address) Coroner.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cem

DATE OF BURIAL MAY 3 1929

20 UNDERTAKER Samuel T. Kemsley

ADDRESS 578 N. Bridge

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 45602

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45602

CERTIFICATE OF DEATH.

100-0

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1151 Myrtle Av (St.) 17-24 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hilbert Tongue

(a) RESIDENCE No. 1151 Myrtle av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. 10 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Blk	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 6/10/1910

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18	10	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wm C Tongue

11 BIRTHPLACE OF FATHER (city or town) West River (State or country) Md

12 MAIDEN NAME OF MOTHER Serena Ennis

13 BIRTHPLACE OF MOTHER (city or town) West River (State or country) Md

14 Informant Wm C Tongue (Address) 1156 Myrtle

15 Filed 19 Per Registrar

C. HARRISON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/2 1924

17

I HEREBY CERTIFY, That I attended deceased from 4/25 , 1924 , to 5/2 , 1924 ,

that I last saw him alive on 5/1 , 1924 ,

and that death occurred, on the date stated above, at 8 a , m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Geo W Goldman , M. D.

, 19 (Address) 856 N Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL MAY 1924 19

20 UNDERTAKER Samuel T Hemsley

ADDRESS 578 W Biddle St

CAUSE OF DEATH to be plainly written, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 45603 HEALTH DEPARTMENT—CITY OF BALTIMORE E 45603

CERTIFICATE OF DEATH. 31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 426 Federal ST., 9-19 WARD)

2-FULL NAME Antonia Morgan

(a) RESIDENCE NO. 426 Federal ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. 9 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: None

6 DATE OF BIRTH (month, day, and year): July 1920

7 AGE: 8 Years 9 Months 10 Days If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Robert Morgan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Mattie Rice

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Mattie Morgan

(Address): 426 E Federal

Filed MAY 3-1923 HAMPSON JOHNS M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5-1 1923

17 I HEREBY CERTIFY, That I attended deceased from 4/19 1923, to 5-1 1923, that I last saw her alive on 5-1 1923, and that death occurred, on the date stated above, at 10 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia X

Pulmonary Tuberculosis

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) B. Hampson Johns, M. D.

5/1, 1923 (Address) 426 E Federal

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Lawn DATE OF BURIAL MAY 4 1923

20 UNDERTAKER: Samuel T. Hemsley ADDRESS 578 N Biddle

TION is very important See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45604

CERTIFICATE OF DEATH

129 E 45604

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 413 N Hoffman St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Richard Hall

(a) RESIDENCE NO. 413 N Hoffman St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Willie Annie Hall

6 DATE OF BIRTH (month, day, and year): 1861

7 AGE: Years 68 Months Days

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Waiter 070

(b) General nature of industry, business, or establishment in which employed (or employer): Chesapeake

(c) Name of employer: S. S. Co

9 BIRTHPLACE (city or town) .....

(State or country) King Queen Co. Virginia

PARENTS

10 NAME OF FATHER Dutmore

11 BIRTHPLACE OF FATHER (City or town) .....

(State or country) Va

12 MAIDEN NAME OF MOTHER Dutmore

13 BIRTHPLACE OF MOTHER (city or town) .....

(State or country) Va

14 Informant: Willie Annie Hall

(Address) 413 N Hoffman

15 Filed ..... 19 .....

MAY 3 - 1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4-30 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 2, 1928, to Apl 30, 1929, that I last saw h[illegible] alive on Apl 24, 1929, and that death occurred, on the date stated above, at 2 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac Vascular Renal

(duration) ..... yrs. 7 mos. ..... ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) ..... yrs. 2 mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) [illegible] M. D.

5/1, 19 29 (Address) 1302 Druid Hill

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — Date of Burial MAY 3 1929

20 UNDERTAKER: Saml T Kemsley — ADDRESS 578 N Eutaw

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45605 HEALTH DEPARTMENT—CITY OF BALTIMORE E 45605

CERTIFICATE OF DEATH

1—PLACE OF DEATH REGISTERED NO. 101-09

CITY OF BALTIMORE: (No. 419 S. Newkirk ST. 26-37 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harry W. Forrester

(a) RESIDENCE NO. 419 S. Newkirk ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52yr mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A. Forrester

6 DATE OF BIRTH (month, day, and year) March 17-1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	1	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist 831

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Joseph M. Forrester

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mary C. Schmidt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

11 Informant Mary A. Forrester

(Address) 419 S. Newkirk St.

15 MAY 3-1929 19 C. HARRISON JONES, M. D.
Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1-1929

17 I HEREBY CERTIFY, That I attended deceased from April 26 1929 to May 1 1929 that I last saw him alive on May 1 1929 and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Acute lobar pneumonia

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Oedema of lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm. D. Schmidt, M. D.

May 2 1929 (Address) 701 N. Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oaklawn Cemetery	May 3 1929
20 UNDERTAKER George W. Zirkler	ADDRESS 1737 E. Eager St.

Important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Inf of James & Nettie Garner ✓

45606

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16-001 E 45606

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1428 Madison ave, St. 14-20 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME none.

(a) RESIDENCE. No. 1428 Madison. St., Ward.

(Usual place of abede) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Apl. 30/29 May 1 29.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	0	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER James Garner.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Nettie Randall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address)

15 Filed MAY 3 - 1929 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1929

17 I HEREBY CERTIFY, That I attended deceased from Apl. 30 1929, to May 2 1929, that I last saw h in alive on May 2 1929, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Premature Birth.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) acute myocarditis.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? No Date of

Was there an autopsy? none

What test confirmed diagnosis? Examination

(Signed) Clinton Mentzer, M. D.

, 19 (Address) 1730 Linden ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS MAY 3 - 192

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45607 — 74-006 — E 45607

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 717 W. Fayette St. WARD 26)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Virginia Ford

(a) RESIDENCE NO. 717 W. Fayette St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, ~~Married~~, Widowed, or Divorced, (write the word): widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Daniel P. Ford

6 DATE OF BIRTH (month, day, and year): Jan 1 1862

7 AGE — Years: 67 — Months: 4 — Days: — — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Nurse

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Crisfield Md

PARENTS

10 NAME OF FATHER: Silas Tyler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Fairmont Va

12 MAIDEN NAME OF MOTHER: Charlotte Summers

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Crisfield Md

14 Informant: Mrs Esther Ford

(Address): 717 W. Fayette

15 Filed MAY 3 1929 — HAMILTON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 1 1929

17 I HEREBY CERTIFY, That I attended deceased from Apr. 26, 1929, to May 1, 1929, that I last saw her alive on May 1, 1929, and that death occurred, on the date stated above, at 9 38 m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis (3 yrs)
Cerebral Hemorrhage

(duration) yrs. 6 mos. 5 ds.

CONTRIBUTORY (Secondary): Pulmonary Congestion

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Ophthalmoscopic Test

(Signed) J. M. Dillon for autopsy, M. D.

May 3 1929 (Address) 621 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	May 4 1929
20 UNDERTAKER: J. Frank Bowers	ADDRESS: 207 S. Eutaw

Important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 45608 HEALTH DEPARTMENT—CITY OF BALTIMORE 1691 001 E 45608

CERTIFICATE OF DEATH.

1-PLACE OF DEATH 211 N Dunstall Ave REGISTERED NO.

CITY OF BALTIMORE: (No. 211 N ST. Dunstall WARD 14 (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant white

(a) RESIDENCE NO. 211 N ST. Dunstall WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: wh

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 5-1-29

7 AGE Years | Months | Days: 1/4 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Infant
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER Otis White

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER Mary Tucker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant Mary White
(Address) 211 N Dunstall Ave

15 Filed MAY 3 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-3 1929

17 I HEREBY CERTIFY, That I attended deceased from 5-1, 19 29, to 5-3, 19 29

that I last saw h[illegible] alive on 5-2, 19 29,

and that death occurred, on the date stated above, at 1 9. m.

The CAUSE OF DEATH* was as follows:

Prematurity (6 month)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) W. Barkley Butler, M. D.

, 19 (Address) 425 N. Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL | DATE OF BURIAL 19

20 UNDERTAKER | ADDRESS

MAY 3 - 1929

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45609 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 45609

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2724 N Calvert ST. 17-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Laura Rebecca Langley

(a) RESIDENCE NO. 2724 N Calvert ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. 4 mos. 3 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Jany 1 - 1858

7 AGE — Years: 71 | Months: 4 | Days: 3 | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: James R Langley

11 BIRTHPLACE OF FATHER (city or town) (State or country): St Marys Co Md.

12 MAIDEN NAME OF MOTHER: Indiana Milburn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): St Marys Co Md

14 Informant: Lula Langley
(Address): 2724 N Calvert

15 Filed: MAY 3 1929 Registrar C. HAMPSON JONES, M. D.
Bur. —

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 3 - 1929

17 I HEREBY CERTIFY, That I attended deceased from April 24, 1929, to May 3, 1929, that I last saw her alive on May 2, 1929, and that death occurred, on the date stated above, at 7-40 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart disease

(duration) Did not Know yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Rheumatism

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A K Bonsack, M. D.

(Address) 117 N Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys City Md — DATE OF BURIAL: May 4 1929

20 UNDERTAKER: W. F. Lankford Sons — ADDRESS: N. Y. Pa.

Important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 45610 HEALTH DEPARTMENT—CITY OF BALTIMORE E 45610

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruth Stevens

(a) RESIDENCE No. 133 John St ST., WARD

(Usual place of abode) Syracuse NY (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1921

7 AGE: Years 8 | Months | Days | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Wesley

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Ruth M. Jost

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant (Address)

15 May 3-1929 C. Hampson Jones, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1929

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1929 to May 3, 1929.

that I last saw her alive on May 3, 1929,

and that death occurred, on the date stated above, at 12 [illegible] m.

The CAUSE OF DEATH* was as follows:

Brain Tumor Brain

Stem - malignant

(duration) yrs. 10 mos ds.

CONTRIBUTORY (Secondary) Operation May 3, 1929

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of May 3, 1929

Was there an autopsy? - yes

What test confirmed diagnosis? - autopsy & Surgeon

(Signed) I. Ridgeway Trimble M. D.

May 3 1929 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Syracuse N Y

DATE OF BURIAL 5/3/29

20 UNDERTAKER Joseph Ahrens

ADDRESS 221 Bway

Cor.—10-10-29—A Co.—100 Bks.

E 45611

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

185 E 45611

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Balto City Hospital 4-18 St., Ward)

2-FULL NAME Bartlett F. Powers

(a) RESIDENCE NO. 728 E North ave St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred ?yrs. mos. ds. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 8 1904

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	20	3	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Electrician 029
(b) General nature of industry, business, or establishment in which employed (or employer) Journeyman
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Wm Powers

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER Ellen Leonard

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant Ellen Powers
(Address) 728 E North ave

15 Filed 6 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:
Fracture 3rd Cervical Vertebrae Accident

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cancer

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Bird River

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Benton, M. D.

5 3 1929 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cemetery	5/4/29

20 UNDERTAKER George J Britt ADDRESS 1735 Hoffman

DATE SHOULD be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45612 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 45612

1—PLACE OF DEATH

CITY OF BALTIMORE, (No. [illegible] ST., 3-5 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Gerrald John Pellum

(a) RESIDENCE NO. 58 Granby ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	16			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Wash. D.C.

PARENTS

10 NAME OF FATHER John

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Records

(Address)

15 Filed 3-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-2-29

17

I HEREBY CERTIFY, That I attended deceased from 3-28 [illegible] 19 29, to 5-2 19 29.

that I last saw h[illegible] alive on 5-2 19 29

and that death occurred, on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Myocardial Insufficiency

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible] M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Washington D.C.	May 5 1929
20 UNDERTAKER Wm Cook	ADDRESS 1217 St Paul St

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 45613

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

24-35-90 E 45613

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1133 Haubert St. St., Ward)

2-FULL NAME Mary Barry.

(a) RESIDENCE NO. 1133 Haubert St. St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. ---- How long in U. S., if of foreign birth 54 yrs. ---- mos. ---- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White.	Widow.

5a If ~~married~~ widowed, ~~wife~~ ~~husband~~ of ~~the~~ ~~deceased~~ (or) WIFE of Thomas Barry.

6 DATE OF BIRTH (month, day, and year) February 14, 1866

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	68	2	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) England.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Sarah Cummings. (daughter)
(Address) 1133 Haubert St.

15 Filed ....19.... C. HAMPSON JONES, M. D. Registrar
By ....

CORONER'S CERTIFICATE OF DEATH.

16 DATE OF DEATH (month, day, and year) May 1, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Organic disease of the Heart.

CONTRIBUTORY (Secondary) (duration) ....yrs. ....mos. ....da.

18 Where was disease contracted (duration) ....yrs. ....mos. ....da.
If not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? History
(Signed) [illegible] M. D.
5/3 . 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery DATE OF BURIAL May 4 1929

20 UNDERTAKER Margaret E. Flynn ADDRESS 1422 Light St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45614

HEALTH DEPARTMENT—CITY OF BALTIMORE

49 E 45614

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 308 S Albemarle 395 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rosaria Dicicco

(a) RESIDENCE NO. 308 S Albemarle WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 4 1906

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	10	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Maxwell

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Loretta Brigola

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Mary Dicicco

(Address) 308 S Albemarle

15 Filed MAY 3 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 1929

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1928, to May 1, 1929, that I last saw h e alive on May 1, 1929, and that death occurred, on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Sarcoma—(Leg)

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter W White Jr, M. D.

May 3, 1929 (Address) 2811 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	May 4 1929
20 UNDERTAKER	ADDRESS
M. W. E. Dippel & Son	

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 45615

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 45615

188-103

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Johns Hopkins Hospital St., 2-4 Ward)

2-FULL NAME Anna Chmilewska

(a) RESIDENCE NO. 234 S. Ann St., Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 19/1916

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	12	9	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School Girl
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) .....
(State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Stephen Chmilewska

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Poland

12 MAIDEN NAME OF MOTHER Wladyslawa Jankowska

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Poland

14 Informant Mother
(Address) 234 S. Ann St

15 Filed MAY 3-1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intraabdominal Hemorrhage
Accidently run over by autotruck
200 block S. Ann St

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) J. C. Cullen, M. D.

5/3/29 19 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	May 4 1929
20 UNDERTAKER	ADDRESS
John M. Weber	401 E. Chase St

...tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill out CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45616

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 45616

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST., W. B. 37 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Wilhelmina Howard

(a) RESIDENCE NO. 3424 E. Lombard st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edgar Howard

6 DATE OF BIRTH (month, day, and year) 1906

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	23			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George D. Kelker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Kate Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed 5-3-1929 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 13, 1929, to May 2, 1929, that I last saw her alive on May 2, 1929, and that death occurred, on the date stated above, at 7.45 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculous laryngitis

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical and lab.

(Signed) Emma C. Smith, M. D.

5-3-, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem	May 6 1929
20 UNDERTAKER	ADDRESS
John C. Miller & Son	E. Oliver

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

(Clayton) ✓

E 45617 HEALTH DEPARTMENT—CITY OF BALTIMORE E 45617

118-002

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST., WARD) 9-18

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Sarah Clayton

(a) RESIDENCE NO. 216 Harford Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Joseph E. Clayton

6 DATE OF BIRTH (month, day, and year) Dec. 15 1851

7 AGE	Years	Months	Days 18	If LESS than 1 day, hrs. or min.
	77	4	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Thomas Reynolds

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Elizabeth Webb

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Minnie Cowles

(Address) 216 Harford Ave Balto. Md

15 Filed 6, 1929 C. HAMPSON JONES, M. D. Registrar

3-1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-3-29

17

I HEREBY CERTIFY, That I attended deceased from 5-2-29, 19, to 5-3-29, 19,

that I last saw her alive on 5-3-29, 19

and that death occurred, on the date stated above, at 6 10 P. m.

The CAUSE OF DEATH* was as follows:

Obstetrical obstructed due to volvulus and Post. Operative adhesions

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 5-2-29

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) C. S. Zimmerman M. D.

, 19 (Address) St. Joseph Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ficke M. E. Cemetery	May 6 19 29
20 UNDERTAKER Clarence E. Arthur	ADDRESS Fork Md

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45618

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-0.01

E 45618

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1222 S. Ellwood Ave. ST 1-1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rose Grabowska

(a) RESIDENCE NO. 1222 S. Ellwood Ave. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

(a) If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 24, 1926

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	10	6	

8 OCCUPATION OF DECEASED

(a) Trade, professiin or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Frank Grabowski

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country)

12 MAIDEN NAME OF MOTHER Rose Stefanska

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country)

14 Informant Rose Grabowska
(Address) 1222 S. Ellwood Ave

15 Filed MAY 4-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-2-29

17 I HEREBY CERTIFY, That I attended deceased from April 26, 19 29 to May 2, 19 29, that I last saw h er alive on May 2, 19 29 and that death occurred, on the date stated above, at 2:30 p. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) I. B. Bronushas I. B. Bronushas, M. D.

(Address) 3037 O'Donnell St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus	5-6- 19 29
20 UNDERTAKER St. Stephan J. Fialkowski Inc. Stephan J. Fialkowski, Inc.	ADDRESS 1000 S. Kenwood A

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45619

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45619

CERTIFICATE OF DEATH

38

1—PLACE OF DEATH

REGISTERED NO. 23-31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1015 Plum ST., 23 WARD)

2—FULL NAME Maggie Wise

(a) RESIDENCE NO. 1015 Plum ST., 23 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Col.	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	46	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Carrie Jackson

(Address) 506 S. Honore St.

15 5-4-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/2/29

17 I HEREBY CERTIFY, That I attended deceased from 4/8/29, to 5/2/29, that I last saw her alive on 5/2/29, and that death occurred, on the date stated above, at 9.30 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. Hampson Jones, M. D.

5-3-29 (Address) 905 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL 5 May 4 1929

20 UNDERTAKER John H. Tradium — ADDRESS 1027 Druid Hill

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45620 E 45620

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 90

CITY OF BALTIMORE: (No. 2703 Chesterfield Ave ST. 8-45 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie Oheim

(a) RESIDENCE NO. 2703 Chesterfield Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Henry Oheim

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Fredrick Schweer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Wm. Henry Oheim

(Address) 2703 Chesterfield Ave

15 Filed 4-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1929

17 I HEREBY CERTIFY, That I attended deceased from 4-24 1929 to 5-3 1929

that I last saw h alive on 5-1 1929

and that death occurred on the date stated above, at 1:30 a. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

Gall Stones

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) M. D.

5-3 1929 (Address) 700 N. Belnord Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	May 6 1929
20 UNDERTAKER Henry Hoen & Son	ADDRESS 1301 E Eager St

Important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 45621

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. E 45621

1-PLACE OF DEATH Bon Secours Hospital

CITY OF BALTIMORE: (No. Raspeburg, Md. ST. 10-27 WARD)

REGISTERED NO. ..... (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hugh A. Biddison

(a) RESIDENCE NO. Raspeburg, Md. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 4 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 17 1862

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
67	1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer): Truck Farm

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Co. Maryland

PARENTS

10 NAME OF FATHER: Abraham Biddison

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Co. Maryland

12 MAIDEN NAME OF MOTHER: Hester Forber

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Co. Maryland

14 Informant: Mrs Ellie Biddison

(Address) Cole & Norwood Aves. Lochearn

15 4-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 26, 1929, to May 1, 1929, that I last saw h[illegible] alive on May 1, 1929, and that death occurred, on the date stated above, at 11 45 p.m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis c
cardiac dilatation & decompensation

(duration) 7 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Luis

(duration) 7 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) Thos. C. Stacy, Jr. M. D.

, 19 (Address) Bon Secours Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery — DATE OF BURIAL: May 4 1929

20 UNDERTAKER: Frederick Lucas & Son — ADDRESS: Fullerton

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 45622 HEALTH DEPARTMENT—CITY OF BALTIMORE E 45622

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. 19-27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha Cooms

(a) RESIDENCE No. 1709 W. Lexington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
f	B.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 4/10-1928

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	13	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... none

(b) General nature of Industry, business, or establishment in which employed (or employer) .....

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Cooms

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Nellie Richardson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Interment Records

(Address) JOHNS HOPKINS HOSPITAL

15 4-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1929

17

I HEREBY CERTIFY, That I attended deceased from May 1, 1929, to May 3, 1929, that I last saw her alive on May 3, 1929, and that death occurred, on the date stated above, at 6.50 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Pertussis

(duration) yrs. 1½ mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Blood count

(Signed) J. C. Goodwin, M. D.

May 4, 1929 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Mt Auburn DATE OF BURIAL May 6th 29

20 UNDERTAKER Samuel E. Hughes ADDRESS 2364 Mar

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 45623 546

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45623

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Liza Ravenel

(a) RESIDENCE No. 2907 W Johns St Jacksonville Fla ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug 3 1916

7 AGE: Years 12 Months 9 Days If LESS than 1 day, hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Florida

PARENTS

10 NAME OF FATHER: Julien Ravenal

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ga

12 MAIDEN NAME OF MOTHER: Marie Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ga

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

15 [illegible] 4-1929 19

C. HAMPSON JONES, M. D.

Registrar

Dat

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 3 1929

17 I HEREBY CERTIFY, That I attended deceased from April 14, 1929, to May 3, 1929, that I last saw her alive on May 3, 1929, and that death occurred, on the date stated above, at 8 55 P m.

The CAUSE OF DEATH* was as follows:

Mastoiditis

Brain abscess

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Mastoidectomy Apr 25

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) I. S. Trimble M. D.

May 3 1929 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Savannah Ga

DATE OF BURIAL: May 4 1929

20 UNDERTAKER: John O Mitchell Sons

ADDRESS: 1900 Eutaw Place

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45624 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45624

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 17-37-00

CITY OF BALTIMORE: (No.) Baltimore City Hospitals (ST.) (T B-) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lee Robinson

(a) RESIDENCE NO. 742 W. Mulberry st. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Victoria Robinson

6 DATE OF BIRTH (month, day, and year) 1896 (Aug 3.)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
37	33	8	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown 040

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER Daniel Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Elsie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant Hospital Records

(Address)

15 Filed 4-1929, 19 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 27, 19 29, to May 1, 19 29,

that I last saw h. im alive on May 1, 19 29

and that death occurred, on the date stated above, at 11.45 p. m.

The CAUSE OF DEATH* was as follows:

Miliary tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis Clinical & autopsy

(Signed) Henry C. Smith, M. D.

5-2-, 19 29 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	May 5, 1929
20 UNDERTAKER Mrs Katie P. Williams	ADDRESS 3221 Schroeder St.

Important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 45625 HEALTH DEPARTMENT—CITY OF BALTIMORE E 45625

CERTIFICATE OF DEATH.

REGISTERED NO. 13-59

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2422 McCulloh ST. WARD)

2-FULL NAME Elizabeth Perry

(a) RESIDENCE NO. 1222 Lafayette ave ST. WARD 2422 McCulloh

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE C

5 Single, Married, Widowed, or Divorced (write the word) Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Perry.

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE Years 59 Months Days If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Urbana Va

PARENTS

10 NAME OF FATHER Henry Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Fannie Sullivan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mrs F Bell

(Address) 1222 W Lafayette

15 Filed 4-1929 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/1 1929

17 I HEREBY CERTIFY, That I attended deceased from 4/30, 1929, to 5/1, 1929, that I last saw h alive on 5/1, 1929 and that death occurred, on the date stated above, at 3 30 Am

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

X Paralysis

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Benj Lueth, M. D.

5/1, 1929 (Address) 2134 Oh ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn DATE OF BURIAL MAY 4 1929 19

20 UNDERTAKER Samuel Herndon ADDRESS 578 N Bond

SEE INSTRUCTION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 45626 HEALTH DEPARTMENT—CITY OF BALTIMORE E 45626

CERTIFICATE OF DEATH. 101-001

1-PLACE OF DEATH Sinai Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 7-12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Back

(a) RESIDENCE No. 724 N Chester ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) apr 28-1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Sinai Hospital Balto Md

PARENTS

10 NAME OF FATHER George Back

11 BIRTHPLACE OF FATHER (city or town) (State or country) USA

12 MAIDEN NAME OF MOTHER Mary Carbonky

13 BIRTHPLACE OF MOTHER (city or town) (State or country) USA

14 Informant Sinai Hosp. Records. (Address)

15 C. HAMPSON JONES, M. D. Registrar

4-1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1929

17 I HEREBY CERTIFY, That I attended deceased from April 28, 1929, to May 3, 1929, that I last saw her alive on May 3, 1929, and that death occurred, on the date stated above, at 5-05 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia and Empyema Right Lung Pericarditis with effusion (duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Intra partum aspiration of infected fluid (duration) yrs. mos. 5 ds.

Where was disease contracted if not at place of death? Sinai Hospital

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical and autopsy

(Signed) James L Swank, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	May 4 1929
20 UNDERTAKER	ADDRESS
Lilly & Zeiler Inc.	403 N. Wolfe

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 45627

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 45627

REGISTERED NO. 15-23 19

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Balto City Hospital St., Ward)

2-FULL NAME John Nedwell

(a) RESIDENCE NO. 801 Robert St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	about 45			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Marine Fireman
(b) General nature of industry, business, or establishment in which employed (or employer) Steam Ships
(c) Name of employer Hallgarten

9 BIRTHPLACE (city or town) White Bay
(State or country) Ireland

PARENTS

10 NAME OF FATHER Nedwell

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Casper Falkenhan
(Address) 120 S Durham St

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

1925

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Alcoholism

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Coal oil burns + Mixed Coal oil ether (duration) 4 days mos. ds.

18 Where was disease contracted If not at place of death? 801 Robert St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James H Fenton, M. D.

5 4 1929 (Address) 700 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Int Carmel Cem. DATE OF BURIAL May 6 1929

20 UNDERTAKER Lilly & Zeiler Inc. ADDRESS 403 S. Wolfe St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

2E 45628 HEALTH DEPARTMENT—CITY OF BALTIMORE E 45628

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Francis J. Kaney

(a) RESIDENCE NO. Ordway Mills md. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. — mos. 11 ds. How long in U. S., if of foreign birth? 49 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie M. Kaney.

6 DATE OF BIRTH (month, day, and year) May 5 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	59	11	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Francis Kaney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Murphy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 C. HAMPSON JONES, M. D. Registrar

4-1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1929

17

I HEREBY CERTIFY, That I attended deceased from April 21, 1929, to May 2, 1929, that I last saw him alive on May 2, 1929, and that death occurred, on the date stated above, at 8 25 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis Chronic
Aortic Insufficiency
Arteriosclerosis

(duration) 6 yrs mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL May 6 1929

20 UNDERTAKER Lilly

ADDRESS [illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 45629 HEALTH DEPARTMENT—CITY OF BALTIMORE E 45629

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital St. 75-12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Joseph Leishear

(a) RESIDENCE NO. Woodbine Md ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Jos. Leishear

11 BIRTHPLACE OF FATHER (city or town) Howard Co (State or country) Md

12 MAIDEN NAME OF MOTHER Marcella Warfield

13 BIRTHPLACE OF MOTHER (city or town) Howard Co (State or country) Md

14 Informant Anna Leishear (Address) Woodbine Md

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-4 19 29

17

I HEREBY CERTIFY, That I attended deceased from 4-29, 19 29, to 5-4, 19 29.

that I last saw h[illegible] alive on 5-4, 19 29,

and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Postoperative operation for hernia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 4-29-29

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) [illegible], M. D.

19 (Address) St agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lisbon Md.	May 6 19 29
20 UNDERTAKER Weaver Bros Inc	ADDRESS Sykesville

TION is very important. See instructions on back of certificates.

4-1929

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45630

CERTIFICATE OF DEATH

E 45630

1-PLACE OF DEATH

REGISTERED NO. 12-5

City of BALTIMORE: (No. Mercy Hospital St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James E. Doyle

(a) RESIDENCE NO. 406 W. 28th St. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Estella Doyle

6 DATE OF BIRTH (month, day, and year) Nov 15, 1870

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	58	5	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman 32

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer City of Baltimore

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Peter Doyle

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Bridget Kiernan

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Mrs Estella Doyle wife

(Address) 406 West 28th St

15 Filed MAY 4-1929 C. HAMPSON JONES, M. D. Registrar

By RCH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/3/29 19

17 I HEREBY CERTIFY, That I attended deceased from 5/1/29, 19..., to 5/3/29, 19...,

that I last saw him alive on 5/3/29, 19...,

and that death occurred, on the date stated above, at 4 40 AM m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of 5/1/29

Was there an autopsy?

What test confirmed diagnosis? Operation

(Signed) J S Winstead, M. D.

. 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Cemetery — Date of Burial 5 6 1929

20 UNDERTAKER W M Cook — ADDRESS 217 N Howard St

Now should be carefully supplied. Avoid using be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 45631 HEALTH DEPARTMENT—CITY OF BALTIMORE

1,002

14 E 45631

CERTIFICATE OF DEATH.

1-PLACE OF DEATH West Baltimore General

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST. 700 (WARD) 9

2-FULL NAME Mrs. Edith Sommers.

(a) RESIDENCE No. 504 N. Pulaski ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of John Sommers

6 DATE OF BIRTH (month, day, and year) July 18, 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
36	8	9	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John Henry Robbs.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Ida Gallion

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant John Sommers (Address) 504 N Pulaski St

15 Filed 4-7-1929 C. HAMPSON JONES, M. D. Registrar Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/4, 1929

17 I HEREBY CERTIFY, That I attended deceased from 4/27, 1929, to 5/4, 1929, that I last saw her alive on 5/4, 1929 and that death occurred, on the date stated above, at 2:45 a. m

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Pregnancy - Forceps delivery

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 4/27/29

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Jack J. Singer M. D.

5/4, 1929 (Address) West Balto. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet

DATE OF BURIAL May 7th 1929

20 UNDERTAKER William Cook

ADDRESS 1217 St Paul St.

TION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—600 Bks.

E 45632 HEALTH DEPARTMENT—CITY OF BALTIMORE

105 E 45632

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 15-65

CITY OF BALTIMORE: (No. 3102 Winfield Ave. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Isaac Heller

(a) RESIDENCE NO. 3102 Winfield Ave. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Regina K. Heller

6 DATE OF BIRTH (month, day, and year) Mch. 21, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	1	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk-Mens' F.

(b) General nature of industry, business, or establishment in which employed (or employer) Furnishings

(c) Name of employer C. Newman

9 BIRTHPLACE (city or town)
(State or country) Bavaria

PARENTS

10 NAME OF FATHER Leopold Heller

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Bavaria

12 MAIDEN NAME OF MOTHER Lillie Heller

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Bavaria

14 Informant Mrs. L. Whitehill

(Address) 3102 Winfield Ave

15 Filed 4-1929, 19 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3, 1929.

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1916, to May 1, 1929, that I last saw him alive on May 1, 1929, and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Bronchial Asthma

(duration) 13 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Pulmonary Edema Uremia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) M. Schimmel, M. D.

19 (Address) 3101 Garrison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Hebrew Cem	5/5/1929

20 UNDERTAKER Harry Sondheim

ADDRESS 118-20 W. Mt. Royal Ave

Important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 45633

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 45 E 45633

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital ST. 25-12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr Jacob Bloom

(a) RESIDENCE NO. 1601 N. Fourth St Harrisburg Pa ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Bloom

6 DATE OF BIRTH (month, day, and year) Oct 15-1865

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
60	6	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Junk Dealer

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Abraham Bloom

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Mary Jacobs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Mrs Minnie Bloom

(Address) 1601 N. Fourth St

15 4-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-4 1929

17 I HEREBY CERTIFY, That I attended deceased from 4-22, 1929, to 5-4, 1929, that I last saw him alive on 5-4, 1929, and that death occurred, on the date stated above, at 5.25 a m.

The CAUSE OF DEATH* was as follows:

Toxemia and Shock following operation

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Carcinoma Rectum

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death? Harrisburg Pa

Did an operation precede death? yes Date of 4-29-29

Was there an autopsy? No

What test confirmed diagnosis? Proctoscopic

(Signed) H. M. Gruver, M. D.

, 19 (Address) Balt. Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Harrisburg Pa DATE OF BURIAL 5/4 1929

20 UNDERTAKER Zach Lewis ADDRESS 439 E Balto

TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 45634

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

88-103

E 45634

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Franklin Square Hospital St., 18-24 Ward)

2-FULL NAME Loretta Toner

(a) RESIDENCE NO. # 139 S. Poppleton St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. 6 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
female	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 6, 1868.

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
60	6	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work house work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John Toner

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Roseine McKenna

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore, Md.

14 Informant Mrs Mary T. McKenna
(Address) 714 Washington Blvd.

15 Filed MAY 5-1929 16 C. HAROLD JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2, 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ~~her~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Struck by automobile on Fulton Ave. between Fayette & Baltimore St. - Fractured Skull? Fracture Ribs, left side & internal injuries

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. H. Brooke M. D.

5/4. 1929 (Address) 3601 - 5th

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem.

DATE OF BURIAL May 6, 1929

20 UNDERTAKER J. Cowan & Son.

ADDRESS 411 Holliday St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

224170

E 45635

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 45635

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 23-31 WARD)

2-FULL NAME Florence Partee

(a) RESIDENCE NO. 117 W. Hamburg ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	B	Married

5a If married, widowed, or divorced (HUSBAND) of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
31			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer 040

9 BIRTHPLACE (city or town) (State or country) N. Car

PARENTS

10 NAME OF FATHER Charlie

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Car

12 MAIDEN NAME OF MOTHER Maggie Stone

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Car.

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed MAY 5 1929, 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 1929

17 I HEREBY CERTIFY, That I attended deceased from April 5, 1929, to May 1, 1929, that I last saw him alive on May 1, 1929, and that death occurred, on the date stated above, at 10:55 P m.

The CAUSE OF DEATH* was as follows:

By extension

Cerebral hemorrhage

Hypertension

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) C. H. Jones, M. D.

(Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Salisbury N C

DATE OF BURIAL 5/5/ 1929

20 UNDERTAKER Walter B. Spry

ADDRESS 1390 W Hamburg St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45636

CERTIFICATE OF DEATH

20 72-20 E-45636

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St. 72-20 Ward)

2-FULL NAME Harry Gaines

(a) RESIDENCE NO. 210 W. Hamburg St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Viola Gaines

6 DATE OF BIRTH (month, day, and year) July 9, 1885

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	43	9	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Egerton Bros.

9 BIRTHPLACE (city or town)
(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Mrs. Viola Gaines
(Address) 210 W. Hamburg St.

Filed 5-7-1929 HAMPSON JONES, M. D. Registrar
By Rigl.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2, 1929. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ruptured Coronary Artery, with Pericardial Hemorrhage, Accidental.

1 hour. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted? 26 E. Pratt St.
If not at place of death? Egerton Bros.

Did an operation precede death? No. Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) Eugene Zeller, M. D.

5/3/. 1929 (Address) 2739 Eastern Ave.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Albion Cemty

DATE OF BURIAL 5/5 1929

20 UNDERTAKER Walter B. Spriggs

ADDRESS 1319 W Hamburg St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45637 E 45637

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5713 Liberty Hgts Ave S., 28-64 WARD)

REGISTERED NO. 47

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha J Babcock

(a) RESIDENCE NO. 5713 Liberty Hgts ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) ~~WIFE~~ of Rev Dr Wm C Babcock

6 DATE OF BIRTH (month, day, and year) May 23-1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	59	11	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co Md

PARENTS

10 NAME OF FATHER Wm F Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Sarah Appleby

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Rev Dr Wm C Babcock

(Address) 5713 Liberty Hgts Ave

15 Filed 5-1929 G H JONES, M. D. Registrar

By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 1 1929

17

I HEREBY CERTIFY, That I attended deceased from Feb 28, 1929, to May 1, 1929,

that I last saw h alive on May 1, 1929,

and that death occurred, on the date stated above, at 8:20 a m.

The CAUSE OF DEATH* was as follows:

Cause of Death

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Contributing Cause

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of July 1928

Was there an autopsy? yes

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

(Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lloyd Ridge DATE OF BURIAL May 6 1929

20 UNDERTAKER H A Marshall ADDRESS 3539 Fall Road

TION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45638

E 45638

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Security & Sanatorium on Hay (or) St. Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Howard M. Rollins

(a) RESIDENCE NO. Parkland Ave 4407 St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Alice Rollins

6 DATE OF BIRTH (month, day, and year): Sept 2 - 1869.

7 AGE: Years 59 Months 8 Days IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Oyster Packer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Virginia

(State or country)

PARENTS

10 NAME OF FATHER: Stephen Rollins

11 BIRTHPLACE OF FATHER (city or town): Virginia

(State or country)

12 MAIDEN NAME OF MOTHER: Susie Lobbs

13 BIRTHPLACE OF MOTHER (city or town): Virginia

(State or country)

14 Informant: Alice Rollins

(Address): 4407 Parkland

15 Filed MAY 5-1929 Per C. HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 3 29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Val. Cardiac Insuff.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Sarcoma

(duration) ..... yrs. ..... mos. ..... ds.

May 5 (Signed) W. T. Talley M. D.

(Coroner)

, 19 29 (Address) 1637 Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem. C. Franck

Date of Burial: May 6 1929

20 UNDERTAKER: Chas. E. Franck

ADDRESS: 502 Madison Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45639

CERTIFICATE OF DEATH

90 E 45639

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2027 N. Fulton Ave ST., 15-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Melville Rankin Gemmill

(a) RESIDENCE NO. 2027 N. Fulton Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Edna Norris Gemmill

6 DATE OF BIRTH (month, day, and year): Aug 8 1860

7 AGE: Years 68 Months 8 Days 26 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: B & O. R.R

9 BIRTHPLACE (city or town) (State or country): Cross Roads York Co. Penna

PARENTS

10 NAME OF FATHER: William L Gemmill

11 BIRTHPLACE OF FATHER (city or town) (State or country): Penna

12 MAIDEN NAME OF MOTHER: Hannah Meads

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Edna Norris Gemmill
(Address) 2027 N Fultons ave

15 Filed MAY 5 - 1929 G. HAMPSON JONES, M. D. Registrar
Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 4th 29

17 I HEREBY CERTIFY, That I attended deceased from May 1st, 1929, to May 4th, 1929, that I last saw h alive on May 4th, 1929 and that death occurred, on the date stated above, at 10 30 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Palpitation & Auscultation

(Signed) G. Hampson Jones, M. D.

5/4, 1929 (Address) 1744 N. North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: West Liberty M.E. Church Baltimore Co. Md.

DATE OF BURIAL: May 7 1929

UNDERTAKER: Chas. G. Black

ADDRESS: 142 W. North ave

Important: See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 45640

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 45640
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3017-1 Rosalie Ave ST., 27-43 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Leslie McManus

(a) RESIDENCE No. 3017-1 Rosalie Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of George W. McManus

6 DATE OF BIRTH (month, day, and year) 2-15-1901

7 AGE	Years	Months	Days	If LESS than 1 day ... hrs or ... min.
	28	2	17	X

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none ~~Housework~~

(b) General nature of industry, business, or establishment in which employed (or employer) housewife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER D. X. Gieniny

11 BIRTHPLACE OF FATHER (city or town) Rochester N.Y. ~~Rochester~~ Baltimore Md

12 MAIDEN NAME OF MOTHER Mary T. Wright

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14

Informant George W. McManus

(Address) 3017-1 Rosalie Ave

15

Filed MAY 5-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1929

17

I HEREBY CERTIFY, That I attended deceased from ~~June~~ 1926, to May 2, 1929,

that I last saw him alive on May 1, 1929,

and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

Valvular (mitral) disease (?)

(duration) — yrs. mos ds.

CONTRIBUTORY (Secondary) Cardiac Dilatation

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) [illegible], M. D.

19 (Address) 1016 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL 5/6/29

20 UNDERTAKER George J. Ruth

ADDRESS 1733 Harford Ave

IMPORTANT See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 45641

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001

E 45641

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 3-5 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Antony Fatine

(a) RESIDENCE NO. 229 S High St St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) unk

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
about	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) Italy

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (City or town) Italy

(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Italy

(State or country)

14 Informant Miss Carmela

(Address) 229 S High St

15 Filed ....., 19 .....

MAY 5-1929 HARRISON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/3/29 19

17 I HEREBY CERTIFY, That I attended deceased from 5/3/29, 19..., to 5/3/29, 19...,

that I last saw h/m alive on 5/3/29, 19...,

and that death occurred, on the date stated above, at 10 PM m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

unknown (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) J. S. Woodall M. D.

. 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathral — Date of Burial May 7 1929

20 UNDERTAKER M. W. & Dippel Inc — ADDRESS 22 E Lan St

This should be carefully supplied. Avoid abbreviations. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

TROUP.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 45642

E 45642 REGISTERED NO.

1-PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2807 Bernard ST., 12-51 WARD)

2-FULL NAME John Haney Troup.

(a) RESIDENCE No. 2807 Bernard ST., 12 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Laura Troup.

6 DATE OF BIRTH (month, day, and year): Nov. 7-1855

7 AGE: Years 73 | Months 5 | Days 20 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer: B. & O. R. R.

9 BIRTHPLACE (city or town) (State or country): Emmitsburg Md.

PARENTS
10 NAME OF FATHER: John H. Troup
11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.
12 MAIDEN NAME OF MOTHER: Not known
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant: Mrs. Laura Troup
(Address) 2807 Bernard St.

15 Filed MAY 5 - 1929 H. HAMPTON JONES, M. D. Registrar
By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 2 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 9, 1929, to May 2, 1929, that I last saw h[illegible] alive on May 1, 1929 and that death occurred, on the date stated above, at 11.30 A.M.

The CAUSE OF DEATH* was as follows:
Cardiac insufficiency
(duration) yrs. mos 1 ds.
CONTRIBUTORY (Secondary) Cerebral Hemorrhage
(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis?

(Signed) Isaac E. Knapp M. D.
May 2, 1929 (Address) 243 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — DATE OF BURIAL: May 5 1929

UNDERTAKER: Horace F. Burgee — ADDRESS: 2621 Fulton Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45643

CERTIFICATE OF DEATH

100-001

E 45643
REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3674 Falls Road ST., 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James A. Bull

(a) RESIDENCE NO. 3674 Falls Road ST., 13 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Helen M. Bull

6 DATE OF BIRTH (month, day, and year): Feb. 15-1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	65	2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Machinists Helper

(b) General nature of industry, business, or establishment in which employed (or employer): 031

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Co. Md.

PARENTS

10 NAME OF FATHER: John Bull

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Eliza Hilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Mrs. Helen M. Bull
(Address) 3674 Falls Road

15 Filed MAY 5 1929 19 HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 2-1929.

17 I HEREBY CERTIFY, That I attended deceased from April 25 1929, to May 2 1929, that I last saw h... alive on May 2 1929 and that death occurred, on the date stated above, at 3.05 A. m.

The CAUSE OF DEATH* was as follows:

Acute dilatation of Heart

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Same

Did an operation precede death? No Date of no

Was there an autopsy? None

What test confirmed diagnosis? Clinical

5/3 1929 (Signed) Erwin F. Kelly, M. D.
(Address) 608 Fairmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — DATE OF BURIAL: May 6 1929.

20 UNDERTAKER: Horace H. Burgee — ADDRESS: 623 Falls Road

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E45644

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 45644

REGISTERED NO. E 45644

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 732 Granby Ave ST., (WARD) 11-67

2—FULL NAME Mary Rebecca Spurrier

(a) RESIDENCE NO. 732 Granby Ave ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. 6 mos. ds. How long in U. S., if foreign birth? 73 yrs. 4 mos. 25 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Oscar M. Spurrier

6 DATE OF BIRTH (month, day, and year): Dec. 9 1855

7 AGE: Years 73 | Months 4 | Days 25 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Westminster Maryland

PARENTS

10 NAME OF FATHER: Wm. H. Orndorff

11 BIRTHPLACE OF FATHER (city or town) (State or country): Westminster Maryland

12 MAIDEN NAME OF MOTHER: Anna Staines

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Westminster Maryland

14 Informant: Mr. O. M. Spurrier Husband
(Address) 732 Granby Ave.

15 Filed: C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 4-1929

17 I HEREBY CERTIFY, That I attended deceased from Dec, 1928, to May 4, 1929, that I last saw h[illegible] alive on May 2, 1929 and that death occurred, on the date stated above, at 2.35 a m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 7 yrs. — mos. — ds.

CONTRIBUTORY (Secondary): Uterus Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Md

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Examination Physical

(Signed) Marshall B Wirt M. D.

May 4, 1929 (Address) Catonsville Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Westminster Carroll Co Md | DATE OF BURIAL: 5/7/1929

20 UNDERTAKER: Stewart & Monroe Co | ADDRESS: Balto.

IMPORTANT.—See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45645

E 45645

CERTIFICATE OF DEATH.

66

REGISTERED NO. E 45645

1-PLACE OF DEATH

City of BALTIMORE: (No. 2114 St.Paul Street St. 12-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Philip Bartley Watts

(a) RESIDENCE NO. 2114 St.Paul Street St. 12 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. 0 mos. 0 ds. How long in U. S., if of foreign birth? 57 yrs. 3 mos. 12 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Helen Cassard Watts

6 DATE OF BIRTH (month, day, and year) Jan-21-1872

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	57	3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer) Law

(c) Name of employer Self

9 BIRTHPLACE (city or town) Pikesville

(State or country) Maryland

PARENTS

10 NAME OF FATHER Philip Watts

11 BIRTHPLACE OF FATHER (city or town) Pikesville

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Catherine Mettan

13 BIRTHPLACE OF MOTHER (city or town) Pikesville

(State or country) Maryland

14 Informant Mrs.Helen Cassard Watts (wife)

(Address) 2114 St.Paul Street.

15 Filed [illegible] 19 [illegible] JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-3 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) [illegible] M. D.

(Coroner)

5/4, 1929 (Address) 1632 Poland me

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death — yrs., — mos., — ds. In the State — yrs., — mos., — ds.

Where was disease contracted, if not at place of death? —

Former or usual residence —

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery Date of Burial May 6 1929.

20 UNDERTAKER [illegible] & MOWEN COMPANY ADDRESS 103 W. NORTH

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 45646

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45646

CERTIFICATE OF DEATH.

129 E 40646

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4208 Wiltshire ave ST. 26-42 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosalie Hanneschlager

(a) RESIDENCE NO. 4208 Wiltshire ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Hanneschlager

6 DATE OF BIRTH (month, day, and year) Sept 20 1837

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	71	7	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Wenkelberger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Rosalie Hanneschlager

(Address) 4208 Wiltshire ave

15 Filed 5-1929, 19 H. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1929

17 I HEREBY CERTIFY, That I attended deceased from April 25th, 1929 to May 7th, 1929 that I last saw her alive on May 2nd, 1929 and that death occurred, on the date stated above, at 7 50 a.m.

The CAUSE OF DEATH* was as follows:

Uremic Coma

(duration) yrs. 5 mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Hurtzpeter M. D.

19 (Address) 3100 Clarks

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem

DATE OF BURIAL 5-6 1929

20 UNDERTAKER Leonard J. Ruch

ADDRESS 648 S Eutaw ave

TION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45647

CERTIFICATE OF DEATH

E 45647

1—PLACE OF DEATH Union Mem. Hosp. REGISTERED NO. E 45647

CITY OF BALTIMORE: (No. 46-26 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret Alcus

(a) RESIDENCE NO. Camp Holabird ST., WARD West 26.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. [illegible] ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) 10-5-28

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	6	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Washington, D.C.
(State or country)

PARENTS

10 NAME OF FATHER John Alcus

11 BIRTHPLACE OF FATHER (city or town) N.Y.
(State or country)

12 MAIDEN NAME OF MOTHER M. O'Brien

13 BIRTHPLACE OF MOTHER (city or town) N.Y.
(State or country)

14 Informant Hospital Records.
(Address)

Filed 5-1929 C. HAMPSON JAMES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-4-29

17 I HEREBY CERTIFY, That I attended deceased from 4-30, 1929, to 5-4, 1929, that I last saw her alive on 5-4, 1929, and that death occurred, on the date stated above, at 3:7 a. m.

The CAUSE OF DEATH* was as follows:

1 Pyelitis - acute
c Secondary cystitis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) 2) Vesicle Volvulus (Cecum)
Ureteritis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of 5/4/29

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical findings & autopsy

(Signed) William K. Swartzbaugh, M. D.

, 19 (Address) 33d & Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Arlington National	May 6 1929
20 UNDERTAKER	ADDRESS
Harry J. Wilson	153 W. Lombard St

Important: See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 45648 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ **E 45648**

CERTIFICATE OF DEATH

REGISTERED NO. E 45648

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1508 Eutaw Place) (Ward) 4-20

2-FULL NAME Clarence E. Gambrill

(a) RESIDENCE NO. 1508 Eutaw Place St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Helen Gambrill

6 DATE OF BIRTH (month, day and year) Oct 26 1875

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	53	6	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Time Keeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Wm Gambrill

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country)

12 MAIDEN NAME OF MOTHER Sarah Burns

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Helen Gambrill
(Address) 1508 Eutaw Place

15 Filed MAY 5 1929 16 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) May 3rd 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Indigestion (duration) yrs. mos.

CONTRIBUTORY (Secondary) Error of Diet (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) May 3rd 1929 F. H. Lueth (Address) Coroner, M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL May 6 1929

19 UNDERTAKER Harry W. Medefield — ADDRESS 501 E 22nd

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

Drimal

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45649

CERTIFICATE OF DEATH.

138 E 45649

1-PLACE OF DEATH

City of BALTIMORE: (No. Church Home & Hosp. 1139 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nellie Cecelia Drimal

(a) RESIDENCE NO. 3411 Noble St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: f

4 Color or Race: w

5 Single, Married, Widowed, or Divorced, (write the word): m

5a If married, widowed, or divorced (or) WIFE of: Edward J. Drimal

6 DATE OF BIRTH (month, day, and year): 5/30/1904

7 AGE — Years: 24 — Months: 11 — Days: 4 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Howard Holston

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto. Md

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) /

(State or country)

14 Informant Edward J. Drimal

(Address) 3411 Noble St

6 JUN 1929 C. HAMPSON JONES, M. D.

Reg. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/4/29 19

17 I HEREBY CERTIFY, That I attended deceased from 4/26, 1929, to 5/4, 1929, that I last saw h.. alive on 5/4, 1929, and that death occurred, on the date stated above, at 5:50 A m.

The CAUSE OF DEATH* was as follows:

Septicemia from general peritonitis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Influenza & Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? yes Date of 4/26/29

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Ronald A. Cox, M. D.

, 19 (Address) Church Home & Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem. — Date of Burial: May 7 1929

20 UNDERTAKER: John Ulrich — ADDRESS: 208 Bream

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45650

CERTIFICATE OF DEATH

177 E 45650

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St. #25 Ward)

2-FULL NAME Helen W. Oates

(a) RESIDENCE NO. 613 W. Mulberry St., Ward #6.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Negro	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 14 - 1927

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	2	2	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) N. C.

PARENTS

10 NAME OF FATHER Norman Oates

11 BIRTHPLACE OF FATHER (city or town)
(State or country) N. C.

12 MAIDEN NAME OF MOTHER Fannie Davis

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) N. C.

14 Informant Norman Oates
(Address) 613 W. Mulberry St

Filed MAY 6-1929 C. HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ingestion of acid (Phenol)
Laryngeal Oedema
(accidental death)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 613 W. Mulberry St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Geller M. D.

5/6. 19 29 (Address) 2739 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	5-6-1929
20 UNDERTAKER	ADDRESS
Leon Cator	Fremont

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

45651

CERTIFICATE OF DEATH

40 E 45651

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Balto City Hosp ST. 17-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lucinda Taylor

(a) RESIDENCE NO. 608 W. Lafayette Ave. WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1912

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	17			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Chas Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mattie Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Balto City Hospt.
(Address)

15 Filed 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/4/29

17 I HEREBY CERTIFY, That I attended deceased from 4/20, 1929, to 5/4, 1929

that I last saw h er alive on 5/4, 1929

and that death occurred, on the date stated above, at 12 10 a.m.

The CAUSE OF DEATH* was as follows:

Acute right pyosalpinx and
Left salpingo ovarian abscess

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Bronchial pneumonia

Lobular (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 4/26/29

Was there an autopsy? no Removed tubes

What test confirmed diagnosis? Clinical, operation

(Signed) Lt. C. Tompkins, M. D.

5/4, 1929 (Address) Balto City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn

DATE OF BURIAL 5-6-1929

20 UNDERTAKER D. Carl Carter

ADDRESS 916 Lanvale

Important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

E 45652

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 45652

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1142 E. North Ave St. 9-18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William J. Eagle

(a) RESIDENCE NO. 1142 E. North Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 74 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fannie Eagle,

6 DATE OF BIRTH (month, day, and year) April 7th 1855

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	77		27	
			26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Clerk,

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Falls, Md

PARENTS

10 NAME OF FATHER Wm. J. Eagle,

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Catherine Weinhart

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md,

14 Informant Mrs Fannie Eagle

(Address) 1142 E North Ave

15 Filed C. HARRISON JONES, M. D.

Per

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1929

17

I HEREBY CERTIFY, That I attended deceased from May 25, 1929, to June 4, 1929, that I last saw h. alive on June 2, 1929, and that death occurred, on the date stated above, at 7:10 a.m.

The CAUSE OF DEATH* was as follows:

(1) Myocarditis

(2) Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Decompensation

(duration) 5 yrs. mos. ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry Beyle, M. D.

(Address) 1142 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Date of Burial 6/7/29

20 UNDERTAKER L. P. Fussellbaugh ADDRESS 1116 E Baltimore

JY 6-1929

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 45653

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 45653

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2854 Harford ave ST. 9-4 WARD)

2-FULL NAME Mary Geiselman

(a) RESIDENCE NO. 2854 Harford ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced. (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of August Geiselman

6 DATE OF BIRTH (month, day, and year) July 16-1848

7 AGE Years 80 Months 9 Days 19. If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Peter Reinack

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER dont Know.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Alvina Teufel

(Address) 2857 Harford ave

15 Filed MAY 6 - 1929 C. HAMPSON JONES, M. D. Registrar Per [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1929

17 I HEREBY CERTIFY, That I attended deceased from April 18, 1929, to May 5, 1929.

that I last saw her alive on May 5, 1929,

and that death occurred, on the date stated above, at 9.45 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Geo. J. Zimmerman M. D.

5/5, 1929 (Address) 2857 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery DATE OF BURIAL May 7. 1929

20 UNDERTAKER Mr. & Mrs. John H. Teufel & Son ADDRESS 201 N. Fayette

Spec.—2-29-28—L. F. S.—500 Bks.

E45654

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45654

CERTIFICATE OF DEATH

21-001

REGISTERED NO. E 45654

1—PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. ..... ST., 13-57 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Milton Hitt

(a) RESIDENCE NO. 3513 Ash ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	married

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Alice Hitt

6 DATE OF BIRTH (month, day, and year) Feb 28 1906

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	23	2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work mechanic

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) ..... (State or country) Va

PARENTS

10 NAME OF FATHER Milton Hitt

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Va

12 MAIDEN NAME OF MOTHER Anna Stifflet

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Va

14 Informant Alice Hitt

(Address) 3513 Ash St

15 Filed ..... 19 .....

C. HAMPSON JONES, M. D.

Registrar

6-1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1929, to May 4, 1929, that I last saw him alive on May 1, 1929, and that death occurred, on the date stated above, at 11.15 p. m.

The CAUSE OF DEATH* was as follows:

Pneumococcus Cerebro spinal meningitis

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. K. Gulick, M. D.

5/4, 1929 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampden	May 7, 1929
20 UNDERTAKER	ADDRESS
Ehrmantraut	2116 Eastern Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45655

CERTIFICATE OF DEATH

129 ✓ **E 45655**

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3664 Ash St ST. 12-5 WARD

2—FULL NAME Holness Cooper.

(a) RESIDENCE NO. 3664 ash St. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Louise Cooper

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
about 70				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Louise Cooper

(Address) 3664 Ash St

15 Filed MAY 6-1929 H. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 29.

17 I HEREBY CERTIFY, That I attended deceased from April 30th, 1929, to May 5th, 1929, that I last saw h alive on May 4th, 1929, and that death occurred, on the date stated above, at 12:5 a. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilation.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis. Hig B.P. Probable Chronic Nephritis (duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical & Typical Findings

(Signed) H. T. Jellal, M. D.

May 6, 1929 (Address) 3614 Falls Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary Hampden	May 7, 1929
UNDERTAKER Chenoweth Son	ADDRESS 3615 Elmland

Spec.—1-10-21—M&T—1500 Bks.

Stanley Urlakis

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45656

65-001

CERTIFICATE OF DEATH.

E 45656

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 428 Brice ST. 70-27 (WARD)

2-FULL NAME Stanley Urlakis

(a) RESIDENCE NO. 428 Brice ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Amila

6 DATE OF BIRTH (month, day, and year): 1868

7 AGE: Years 61; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tailor

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Lithuania

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Lithuania

12 MAIDEN NAME OF MOTHER: Amila Bartel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Leonard Urlakis

(Address) 428 Brice St

15 Filed MAY 6-1929 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 4 1929

17 I HEREBY CERTIFY, That I attended deceased from June 1 1928 to May 4 1929

that I last saw alive on May 3 1929

and that death occurred, on the date stated above, at 7:30 p.m.

The CAUSE OF DEATH* was as follows:

Chr. Lymphatic Leukemia

(duration) 2 yrs. — mos — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) M. Feinberg, M. D.

5/5 1929 (Address) 682 Work Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetary — DATE OF BURIAL: 5/7 1929

20 UNDERTAKER: Chas. B. Kuchauskas — ADDRESS: 637 S. Paca St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45657 — 100-001 — **E 45657.**

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 5-59

CITY OF BALTIMORE: (No. 1810 Clifton Ave ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Helen L. Chios.

(a) RESIDENCE NO. 1810 Clifton Ave. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 mos. 19 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 18, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		2	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Louis Chios.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Sparta Greece.

12 MAIDEN NAME OF MOTHER Nickoleta Condokes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Sparta Greece

14 Informant Mr. Louis Chios.

(Address) 1810 Clifton Ave

15 Filed MAY 6-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1929

17 I HEREBY CERTIFY, That I attended deceased from May 2 . 1929 . to May 5 . 1929.

that I last saw her alive on May 5 . 1929

and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Bronchitis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? clinically

(Signed) Fred B Smith, M. D.

. . 19 (Address) 11 E. Chase St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemy

DATE OF BURIAL May 6, 1929

20 UNDERTAKER Wm Pickner Sons

ADDRESS North & Pa Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45658

1—PLACE OF DEATH

CERTIFICATE OF DEATH

REGISTERED NO. 1489 E 45658

CITY OF BALTIMORE: (No.) 2417 W. Lafayette Ave (WARD) 6

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Laura A. Newton.

(a) RESIDENCE NO. 12030 109th Ave (Usual place of abode) Ozone Park (WARD) Long Is. N.Y.

Length of residence in city or town where death occurred yrs. mos. 24 ds. (If non-resident give city or town and State) How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married.

a If married, widowed, or divorced HUSBAND of (or) WIFE of Wilson C. Newton

6 DATE OF BIRTH (month, day, and year) Jan. 9, 1869

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
60	3	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Peter Potts.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mary A. Bailey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs Edw. D. Pickers

(Address) 2417 W. Lafayette Ave

15 Filed MAY 6 1929 C. HARRISON JONES, M. D. Registrar.

Par

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3 1929

17 I HEREBY CERTIFY, That I attended deceased from May 3, 1929, to May 3, 1929, that I last saw her alive on May 3, 1929 and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Same diagnosis made by physicians in New York City

What test confirmed diagnosis?

(Signed) Louis de la Rumeney, M. D.

, 19 (Address) 812 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL May 6 1929

20 UNDERTAKER W. J. Buckner & Sons — ADDRESS North & Pa

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45659

CERTIFICATE OF DEATH

129 E 45659

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3419 Elmley Ave. (ST.) 8-48 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ellen E. Plumhoff

(a) RESIDENCE NO. 3419 Elmley Ave. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry J. Plumhoff

6 DATE OF BIRTH (month, day, and year) Apr. 17/1851

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
78		16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa.

PARENTS

10 NAME OF FATHER Adam King

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Geo. E. Plumhoff

(Address) 3419 Elmley Ave

15 5-1929 C. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3/29

17 I HEREBY CERTIFY, That I attended deceased from April 26 1929, to May 3 1929, that I last saw h alive on May 2 1929 and that death occurred, on the date stated above, at 12 45 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Chronic Nephritis - Arteriosclerosis (duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Alma B Lemmon M. D.

5/4, 1929 (Address) 918 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL D. A. Mathews Cem

DATE OF BURIAL May 6 1929

20 UNDERTAKER Philip Henrig

ADDRESS 2016 Orleans St

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45660

CERTIFICATE OF DEATH.

E 45660

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1009 Valley ST., 10-14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel R. Cain

(a) RESIDENCE NO. 1009 Valley ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) 1874 Nov. 16.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
54	5	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer City

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Wm S. Cain

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine J. Brien

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Portland Ireland

14 Informant Helen E. Cain (Address) 1009 Valley st

Filed MAY 6 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1929

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1929 to May 6 1929, that I last saw h alive on May 5, 1929, and that death occurred, on the date stated above, at 6.30 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver

Unknown (duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Bernard Wood, M. D.

May 5, 1929 (Address) 1216 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL May 8, 1929

20 UNDERTAKER Edward W. Conklin — ADDRESS 924 E. Fayette.

ATTENTION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 45661 HEALTH DEPARTMENT—CITY OF BALTIMORE E 45661

CERTIFICATE OF DEATH.

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3102 Woodland Ave. St. 27-56 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary C. Michael

(a) RESIDENCE NO. 3102 Woodland Ave. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. 5 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George H. Michael

6 DATE OF BIRTH (month, day, and year) May 15th. 1840

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	88	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Richard Leonard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ward

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Family

(Address) 3102 Woodland Ave.

Filed MAY 6-1929, 19 C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5th. 1929.

17 I HEREBY CERTIFY, That I attended deceased from Apr 20, 1929, to May 5, 1929, that I last saw her alive on May 4, 1929 and that death occurred, on the date stated above, at 8 A. m

The CAUSE OF DEATH* was as follows:

Arterio - sclerosis

(duration) 10 yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) N. F. Jones, M. D.

May 6, 1929 (Address) 720 N. Howard Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery.

DATE OF BURIAL May 8th 1929.

20 UNDERTAKER Chas. S. Wane & Son ADDRESS 1180 North Royal Ave

TION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Morris

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45662

CERTIFICATE OF DEATH

49

E 45662

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No.) Baltimore 4-27 (ST.) (WARD) La

(If death occurred in hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Teresa Torres

(a) RESIDENCE NO. Unknown ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if foreign birth? 48 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1877

7 AGE — Years: 58 | Months: | Days: | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Greece

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Greece

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Greece

14 Informant: Hospital Records

(Address): Baltimore City Hospitals

15 Filed ..... 19 ..... (Registrar)

MAY 6 - 1928 SOUP NO. 24TH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2, 1928

17 I HEREBY CERTIFY, That I attended deceased from April 19, 1928, to May 2, 1928, that I last saw h[illegible] alive on May 2, 1928, and that death occurred, on the date stated above, at 5.30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Head of Pancreas

Two (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) [illegible] M. D.

, 19 (Address) Balto City Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	May 6 1928
20 UNDERTAKER	ADDRESS
John W Weber & Son	Chester

Spec.—2-29-28—L. F. S.—500 Blks.

45663

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 45663

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1628 Eutaw Place ST. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Dr Bernard Bar

(a) RESIDENCE NO. 1628 Eutaw Place ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Helen Kann Bar

6 DATE OF BIRTH (month, day, and year): Oct 21st 1871

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
57	6	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Dentist

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

PARENTS

9 BIRTHPLACE (city or town) (State or country): Baltimore

10 NAME OF FATHER: Levi Bar

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Caroline Bekerud

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs H. Bar

(Address) 1628 E. P.

15 6-1929 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 4th 1929

17 I HEREBY CERTIFY, That I attended deceased from May 3, 1929, to May 4, 1929, that I last saw h[illegible] alive on May 4, 1929, and that death occurred, on the date stated above, at 11.25 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency ? (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No ~~clinical & Lab~~

What test confirmed diagnosis? Clinical & Lab.

(Signed) Isidor I. Levy, M. D.

May 7, 1929 (Address) 2324 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Hebrew — DATE OF BURIAL: May 7 1929

20 UNDERTAKER: Dan Sondheim — ADDRESS: [illegible]

Spec.—2-29-28—L. F. S.—500 Bks.

E 45664

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45664

CERTIFICATE OF DEATH

31

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1758 Llewelyn Ave ST., 8-16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lena Pearl Hodges

(a) RESIDENCE NO. 1758 Llewelyn Ave ST.

(Usual place of abode)

WARD

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 12, 1909

7 AGE: Years 20; Months 3; Days 22; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Hopewell N.C

PARENTS

10 NAME OF FATHER: Joseph N. Hodges

11 BIRTHPLACE OF FATHER (city or town) (State or country): N C

12 MAIDEN NAME OF MOTHER: Sula Burns

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N C

14 Informant: Elmer L. Hodges Brother

(Address): 1517 W Lanvale St

15 Filed 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 4, 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 29 to May 4 1929, that I last saw h w alive on May 21 1929 and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Pleurisy with Effusion

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary): Pulm Tuberculosis

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R. T. Norris, M. D.

5/4. 19 29 (Address) 1429 E Monument st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Cem.

DATE OF BURIAL: May 7 1929

20 UNDERTAKER: Mrs J. G. Locks.

ADDRESS: 1382 Jefferson

MAY 6 1929 HAMILTON JONES N

E 45665—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45665

CERTIFICATE OF DEATH

161-00

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 832 Aisquith ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Meyer

(a) RESIDENCE NO. 832 Aisquith ST.. WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 3. '29

7 AGE	Years	Months	Days	If LESS than 1 day, 5 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ———

(b) General nature of industry, business, or establishment in which employed (or employer) ———

(c) Name of employer ———

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER James A. Meyer

11 BIRTHPLACE OF FATHER (city or town) Smithfield
(State or country) Va

12 MAIDEN NAME OF MOTHER Lillie Mathews

13 BIRTHPLACE OF MOTHER (city or town) Smithfield
(State or country) Va

14

Informant Vera Meyer

(Address) 832 Aisquith

15

Filed MAY 6 - 1929 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3. '29

17

I HEREBY CERTIFY, That I attended deceased from May 3, 19 29, to May 3, 19 29, that I last saw h— alive on May 3, 19 29 and that death occurred, on the date stated above, at 1:30 p. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam.

(Signed) W. E. Plass, M. D.

, 19 (Address) 1720 E. Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

JOHNS HOPKINS HOSPITAL — 19

20 UNDERTAKER — ADDRESS

Dept. Supervisor Health. MAY 4 - 1929

Important: See instructions on back of certificate.

JOHNS HOPKINS HOSPITAL

Spec.—2-29-28—L. F. S.—500 Bks.

E 45666

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 45666

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. ____ ST. 7 B ST WARD) Baltimore City Hospitals

REGISTERED NO. ____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Helen Jendreskiwitz

(a) RESIDENCE NO. 405 S. Washington st. ST., ____ WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1912 - 7/4 -

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	17	10	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Factory work

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Frank Jendreskiwitz

11 BIRTHPLACE OF FATHER (city or town) ____
(State or country) Poland

12 MAIDEN NAME OF MOTHER Susie ?

13 BIRTHPLACE OF MOTHER (city or town) ____
(State or country) Poland

14 Informant Hospital Records
(Address)

15 Filed MAY 6-1929 ____, 19 ____ C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 18, 1929, to May 4, 1929

that I last saw her alive on May 4, 1929

and that death occurred, on the date stated above, at 8.30 A. m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary
Tuberculosis
(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) ____
(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of ____

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Lab.

(Signed) Henry C. Smith, M. D.

5-4, 19 29 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary

DATE OF BURIAL 5/7 1929

20 UNDERTAKER William Fiedorowicz

ADDRESS 168 Eastern Ave

Spec.—2-29-28—L. F. S.—500 Bks.

E 45667

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 45667

1—PLACE OF DEATH

REGISTERED NO. 20-10

CITY OF BALTIMORE: (No. Sydenham Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Leola HAZEL TYRE

(a) RESIDENCE NO. 329 Ellamont St. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 9 mos. 16 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 19, 1928

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	9	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER James Tyre

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Hazel Ryan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Hazel Tyre

(Address) 329 Ellamont St.

15 Filed MAY 6 - 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 3, 1929, to May 4, 1929, that I last saw her alive on May 4, 1929, and that death occurred, on the date stated above, at 5 30 P m.

The CAUSE OF DEATH* was as follows:

Pertussis

(duration) yrs. 1 mos. 4 da.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? 329 Ellamont St.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Addison Craft, M. D.

5-5, 1929 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Star Cemetery

DATE OF BURIAL May 6, 1929

20 UNDERTAKER Katie R. Williams

ADDRESS 3222 Mt. Schroeder St.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 45668

90 E 45668

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Univ Hospital St. 4-30 Ward)

2-FULL NAME Geo. B. Brown

(a) RESIDENCE NO. Not Known St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 50 | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) 07
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant
(Address)

15 Filed MAY 6 - 1929 H. A. C. JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 22 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) G E Brady M. D.

19 (Address) 1431 Bolton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Dept. of Health. MAY 6 - 1929

3550

Cor.—10-10-29—A Co.—100 Bks.

E 45669

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

3/ E 45669

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 713 Vine St., 4th Ward)

2-FULL NAME Clara Brown

(a) RESIDENCE NO. 713 Vine St., Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Black	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
22			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work .....
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country)

PARENTS

10 NAME OF FATHER .....

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

14 Informant .....
(Address)

15 Filed ..... (19..) C. HAMPSON JONES, M. D., Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Oct 16 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

TB.

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ..... yrs. ..... mos. — ds.

18 Where was disease contracted If not at place of death? — —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Histology

(Signed) M. C. Wades, M. D.

(Address) 1432 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

NOV 6-1929 3551E MUSEUM

UNIVERSITY OF MARYLAND MAY 6 - 1929

Spec.—2-29-28—L. F. S.—500 Bks.

E 45670

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 45670

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) # 9 W. Lafayette (STREET) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baykin Jones

(a) RESIDENCE NO. 9 W. Lafayette Ave. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	C.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella Jones

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	26			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) S. C.

PARENTS

10 NAME OF FATHER Thomas Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. C.

12 MAIDEN NAME OF MOTHER Meddie Woods

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. C.

14 Informant Ella Jones

(Address) 9 W. Lafayette Ave.

15 [illegible]

MAY 6 1929 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 28, 1929, to May 3, 1929, that I last saw him alive on May 3, 1929, and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:

Acute Pneumonia, Influenza

(duration) yrs. 1 mos. 3 ds.

CONTRIBUTORY (Secondary) General Debility

(duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) G. D. Hall, M. D.

, 19 (Address) 426 E 23rd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Camden S. C.	May 6 1929
20 UNDERTAKER Mrs. L. A. Elliott	ADDRESS 1723 Ashland Ave

Spec.—1-10-21—M&T—1500 Bks.

(Rosen)

E 45671 HEALTH DEPARTMENT—CITY OF BALTIMORE **E 45671**

CERTIFICATE OF DEATH.

92

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital ST. 2-54 WARD)

2-FULL NAME Bessie Rosen

(a) RESIDENCE NO. 2515 Madison Ave. ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harris Rosen

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Solomon Halpert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Chandel Meyerowitz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Sam Halpert.
(Address) 2515 Madison Ave

15 C. HAMPSON JONES, M. D. Registrar

6-[illegible]

Bur. .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) J 0 19 29

17

I HEREBY CERTIFY, That I attended deceased from J 14 , 19 29 , to J 5 , 19 29 ,

that I last saw her alive on J 5 , 19 29 ,

and that death occurred, on the date stated above, at 1 10 m.

The CAUSE OF DEATH* was as follows:

Mesenteric Thrombosis.

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Cardiac failure.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Jos. E. Goodman, M. D.

J 5 19 29 (Address) .....

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Southern Ave | DATE OF BURIAL J 7 19 29

20 UNDERTAKER Jack Lewis 1439 E Baltimore St | ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause of death is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45672

CERTIFICATE OF DEATH.

101-09

E 45672

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2810 Delmont ave ST. 5-72 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fredk. W. Eichert

(a) RESIDENCE NO. 2810 Delmont Ave; ST., Washington Park WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. — mos. ds. How long in U. S., if of foreign birth? 30 yrs. — mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emma Eichert

6 DATE OF BIRTH (month, day, and year): March 4. 1864

7 AGE: 65 Years | 2 Months | — Days | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter, 015

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Fredk. Eichert

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Charlotte Florian (Address) 2810 Delmont Ave.

15 Filed 5-6-1929 C. HAMPSON JONES, M. D. Registrar By ACH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 4 1929

17 I HEREBY CERTIFY, That I attended deceased from May 1 1929 to May 4 1929, that I last saw h[illegible] alive on May 4 1929, and that death occurred, on the date stated above, at 4 10, m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

4

(duration) yrs mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) G. Gustav Dill M. D.

5/6 1929 (Address) 1509 W Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem:

DATE OF BURIAL: May 7, 1929

20 UNDERTAKER: C. W. Dill

ADDRESS: 2107 Frdk Ave

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45673 HEALTH DEPARTMENT—CITY OF BALTIMORE 101-001 **E 45673**

CERTIFICATE OF DEATH

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

CITY OF BALTIMORE: (No. [illegible] ST., 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Howard

(a) RESIDENCE NO. 125 Hull ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Wm R.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Harriet

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Records

(Address) BALTIMORE CITY HOSPITALS

15 Filed 6-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1929

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1929, to May 4, 1929, that I last saw him alive on May 4, 1929, and that death occurred, on the date stated above, at 2.25 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory & X Ray

(Signed) H. H. Wells M. D.

. 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary Cemetery

DATE OF BURIAL 5/7 1929

20 UNDERTAKER John H. Gudrin

ADDRESS 1827 Brookfield Ave.

Spec.—2-29-28—L. F. S.—500 Blks.

E 45674

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 45674

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1615 Division ST. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Francis Holt

(a) RESIDENCE NO. 1615 Division ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Holt

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Minnie Holt

(Address) 1615 Division St

15 Filed 6-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4/29

17

I HEREBY CERTIFY, That I attended deceased from April 29, 1929, to May 4, 1929, that I last saw him alive on May 4, 1929 and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Chr. Parenchymatous Nephritis

(duration) 11 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clin. Urinalysis

(Signed) L. M. Beard, M. D.

5/6, 1929 (Address) 2005 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	5-6 1929
20 UNDERTAKER	ADDRESS
David Taylor	19 Pine

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45675

CERTIFICATE OF DEATH.

E 45675

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm White

(a) RESIDENCE No. 22 Poplar Ave. ST., WARD Takoma Park, Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of ~~WIFE of~~ Mary White.

6 DATE OF BIRTH (month, day, and year) July 11 - 1852

7 AGE: Years 76 Months 9 Days 24 If LESS than 1 day, hrs or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer): 015

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): England

PARENTS

10 NAME OF FATHER: Joseph White

11 BIRTHPLACE OF FATHER (city or town) (State or country): England.

12 MAIDEN NAME OF MOTHER: Jane Meadon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England.

14 Informant, Records

(Address) JOHNS HOPKINS HOSPITAL

15 C. HAMPSON JONES, M. D.

16 MAY 6 1929 19 RCH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec. 27, 1928, to May 5, 1929, that I last saw him alive on May 5, 1929, and that death occurred, on the date stated above, at 9 12a m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

Duration - 24 hrs.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of bladder, urinary. (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? Yes Date of Oct - 1928 Washington D.C.

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) G. B. Hurd, M. D.

, 19 (Address) Johns Hopkins Hospital Baltimore Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Rock Creek. Washington D.C. | DATE OF BURIAL: May 8 1929

20 UNDERTAKER: William G. Schaffer | ADDRESS: 1816 Monument

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45676

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

16-001

E 45676

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 909 Warner ST. 21-31 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Gray

(a) RESIDENCE NO. 909 Warner ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col	Single

a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) 5/4/29

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Melvin H Gray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Catharine Gross

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Catherine Gray

(Address) 909 Warner St

15 Filed 19

C. HAMPSON JONES, M. D.

Registrar

6-1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/5/29

17 I HEREBY CERTIFY, That I attended deceased from 5/4, 1929, to 5/5, 1929, that I last saw him alive on 5-/4, 1929 and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Premature Delivery
(7 months)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) D. T. Carmel M. D.

5-6, 1929 (Address) 1329 N. Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Undertaker Feather

ADDRESS

MAY 6 - 1929

Spec.—2-29-28—L. F. S.—500 Blks.

McMahon

E 45677

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-002

E 45677

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hosp ST., 9x17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby McMahon

(a) RESIDENCE NO. 1847 Patapsco St. ST. Towne Point WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) — 5/1/29.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
				5 min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Sd. Joseph's Hospital

PARENTS

10 NAME OF FATHER Frank McMahon.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER — Michael Mason.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant

(Address) JOHNS HOPKINS HOSPITAL

15 6-1929, 19 C. RAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/1/29.

17 I HEREBY CERTIFY, That I attended deceased from 5/1, 19 29, to 5/1, 19 29, that I last saw h... alive on 5/1, 19 29, and that death occurred, on the date stated above, at 10 A.M. m.

The CAUSE OF DEATH* was as follows:

1. Premature birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Premature (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. McBryde, M. D.

, 19 (Address) Sd. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health

ADDRESS MAY 6 - 1929

FOR [illegible] E. WOODALL

Spec.—2-29-28—L. F. S.—500 Bks.

E 45678

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45678

CERTIFICATE OF DEATH

101-001

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 133 N. Linwood Ave. ST. 6th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME E. Wallace Eole

(a) RESIDENCE NO. 133 N. Linwood Ave. ST. 6 WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

3a If married, widowed, or divorced HUSBAND of (or) WIFE of me the late Sarah E. Eole.

6 DATE OF BIRTH (month, day, and year) Aug. 22nd 1858

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
70	8	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Policeman 61

(b) General nature of industry, business, or establishment in which employed (or employer) Eastern Dist.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Philip Eole

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Mrs Bell Bates Daughter

(Address) 133 N. Linwood Ave

15 Filed 6-1929, 19 C. HAMPSON JONES, M. D. Per DRH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4th/29

17

I HEREBY CERTIFY, That I attended deceased from April 21- 1929 to May 4- 1929, that I last saw him alive on May 3- 1929. and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? physical signs

(Signed) Chester Riland, M. D.

5-4-, 1929 (Address) 2532 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery

DATE OF BURIAL May 7th 1929

20 UNDERTAKER Lilly & Geisler

ADDRESS 405 N. Arlington Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45679

E 45679

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 26-37

CITY OF BALTIMORE: (No. 713 S. Tracy ST. [illegible] WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Agnes Roman

(a) RESIDENCE NO. 713 S. Tracy ST., 26 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Joseph Roman

6 DATE OF BIRTH (month, day, and year) April 12 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71		22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Joseph Butler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Elizabeth Mowers

(Address) 713 S. Tracy St

15 6-1929 C. HAMPSON JONES, M. D. Registrar

Per [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 29, 1927, to May 4, 1929, that I last saw h[illegible] alive on May 4, 1929 and that death occurred, on the date stated above, at [illegible] a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma (Gastric)

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) "

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? No Date of ~

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Geo. Kelly, M. D.

5-6, 1929 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cemetery	May 8 1929
20 UNDERTAKER	ADDRESS
[illegible]	[illegible]

Spec.—1-10-21—M&T—1500 Bks.

E 45680 HEALTH DEPARTMENT—CITY OF BALTIMORE **E 45680**

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 303 S. Fremont Ave. (ST.) 77-29 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Frederick W. Hauser.

(a) RESIDENCE NO. 303 S. Fremont Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. 8 mos. 26 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Married

5a If married, HUSBAND of (WIFE) Florence Hauser

6 DATE OF BIRTH (month, day, and year) August 9, 1882.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	8	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Filling station

(b) General nature of industry, business, or establishment in which employed (or employer) attendant.

(c) Name of employer Gret Eastern Oil Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Michael Hauser.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Do not know.

12 MAIDEN NAME OF MOTHER Mary Schleich.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania.

14 Informant Florence Hauser. (wife)

(Address) 303 S. Fremont Ave.

15 6-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5th. 1929

17 I HEREBY CERTIFY, That I attended deceased from March 22nd, 1929, to May 5th. 1929,

that I last saw him alive on May 5th. 1929,

and that death occurred, on the date stated above, at 12.15 a. m.

The CAUSE OF DEATH* was as follows:

Acute endo-pericarditis and odema of the Lungs.

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Acute polyarthritis.

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? -----

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical diagnosis.

(Signed) Otto M. Reinhardt, M. D.

5/6, 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL May 7 1929

20 UNDERTAKER Jos Joerdens & Son — ADDRESS 2179 B—

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 45681 HEALTH DEPARTMENT—CITY OF BALTIMORE E 45681

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1813 McCulloh ST. 14-20 WARD)

2-FULL NAME Geo W Smith

(a) RESIDENCE NO. 1813 McCulloh ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: colored

5 Single, Married, Widowed, or Divorced, (write the word): Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE: Years 56 | Months | Days | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Porter

(b) General nature of industry, business, or establishment in which employed (or employer): 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Jane Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Co.

12 MAIDEN NAME OF MOTHER: Elizabeth Myers

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Co

14 Informant: Jane Smith

(Address) 1813 McCulloh St

15 6-15-1929 19 C. HAMPSON JONES, M. D.

Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 19 29

17 I HEREBY CERTIFY, That I attended deceased from Apr 24, 1929, to May 5, 1929.

that I last saw h... alive on May 1, 1929

and that death occurred, on the date stated above, at 1.10 m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Heart sounds

(Signed) W. A. Pearce, M. D.

, 19 (Address) 2105 Chas st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel

DATE OF BURIAL: May 7 19 29

UNDERTAKER: Clarence E Wright

ADDRESS: 364 W Lanvale

FOR IS very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45682

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 45682

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1725 Bank ST. 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME ELIZABETH PRICILLA HEBRANK

(a) RESIDENCE NO. 1725 Bank ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of - - -

6 DATE OF BIRTH (month, day, and year) January 15,1929

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		3	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Edward Hebrank

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Dorothy Englehardt

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mrs. Dorothy Hebrank (Mother)

(Address) 1725 Bank Street

15 Filed 6-1929 C. HAMPSON JONES, M. D. Registrar.

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 3 1929 to May 5 1929

that I last saw her alive on May 5 1929

and that death occurred, on the date stated above, at 1.45 p. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia
(Simple)

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Cardiac Paralysis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William Hyde M.D.

May 6 1929 (Address) 607 N. Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery — DATE OF BURIAL: May 6 1929

20 UNDERTAKER: Henry Sander & Sons, Inc. — ADDRESS: BALTIMORE ST. & BROADWAY.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45683

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 45683

1—PLACE OF DEATH

BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE (No. 15-21 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Caleb Hessey

(a) RESIDENCE NO. 1607 N. Monroe ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anderson 1855

6 DATE OF BIRTH (month, day, and year) 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Eli Hessey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Eliza

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address)

MAY 6 1929 W. HAMPSON JONES, M. D. Registrar

Per ARP

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4th 1929

17

I HEREBY CERTIFY, That I attended deceased from Dec 1, 1928, to May 4, 1929, that I last saw h[illegible] alive on May 4, 1929 and that death occurred, on the date stated above, at 900 P. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

myocardial insufficiency

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) W. H. Welch, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore

DATE OF BURIAL 5 7 1929

20 UNDERTAKER D. M. Cook

ADDRESS 1217 St Paul St

Spec.—2-29-28—L. F. S.—500 Bks.

E 45684

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

24-001

E 45684

REGISTERED NO.

1—PLACE OF DEATH Baltimore City Hospitals

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST. 6-11 WARD)

2—FULL NAME Louise Nutz (Neutze)

(a) RESIDENCE NO. 140 N. Hare ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1/2 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.

(State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Records of

(Address) Baltimore City Hospitals

Filed 6-1929, 19 C. HAMPSON JONES, M.

Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 19, 1929, to May 4, 1929,

that I last saw her alive on May 4, 1929

and that death occurred, on the date stated above, at 5:40 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage right

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) J. M. Jack M. D.

, 19 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	5 6 19 29
20 UNDERTAKER J. M. Cook	ADDRESS 217 N. Gay St

Spec.—1-12-23—M&T—500 Bks.

Dr Cowen

E 45685 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 45685

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

I-PLACE OF DEATH

CITY OF BALTIMORE: (No. Home for Incurables ST. 15-68 WARD)

2-FULL NAME ~~Hubert + Baker Ave~~ Laura Boss

(a) RESIDENCE No. 2001 Braddish Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 4 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert Boss

6 DATE OF BIRTH (month, day, and year) Jan 19 1879

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min
50	3	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carlisle Penn.

PARENTS

10 NAME OF FATHER Courtland Conser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Hutchinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Margaret Zirrenberger

(Address) 2001 Braddish Ave

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar.

6-1929 Dep. Robb

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6th 1929

17 I HEREBY CERTIFY, That I attended deceased from Jany 2 1929, to May 4th 1929, that I last saw her alive on May 4th 1929, and that death occurred, on the date stated above, at 8.50 a. m.

The CAUSE OF DEATH* was as follows:

Progressive Muscular Atrophy (duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Pulmonary oedema (duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical diagnosis

(Signed) Wm. J. Mayo M. D.

5/6 1929 (Address) Medical Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 5 9 1929

20 UNDERTAKER W. M. Cook

ADDRESS 1217 St Paul St

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45686

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45686

CERTIFICATE OF DEATH

31

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hospital ST. 10-69 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Helder

(a) RESIDENCE NO. 1132 Millington Lane ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mrs. Charles Helder

6 DATE OF BIRTH (month, day, and year) 1794

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Washdriver

(b) General nature of industry, business, or establishment in which employed (or employer) Laundry 023

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER Wm H Helder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Coleman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Hospital Records

(Address)

15 Filed 5-1929, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/4/29

17 I HEREBY CERTIFY, That I attended deceased from 3-23—, 1929, to 5/4/, 1929, that I last saw h alive on 5/4/29, 19.., and that death occurred, on the date stated above, at 6.00 P m.

The CAUSE OF DEATH* was as follows:

Caseous Pneumonia (Tuberculous)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumothorax

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Bac. Clin. & Path

(Signed) Henry C Smith, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Allentown Pa — DATE OF BURIAL 5/7 1929

20 UNDERTAKER Wm. Cook — ADDRESS 1217 St Paul St

Spec.—2-29-28—L. F. S.—500 Bks. C C

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45687 49 E 45687

CERTIFICATE OF DEATH

1—PLACE OF DEATH REGISTERED NO.

CITY OF BALTIMORE: (No. 533 S Chapel St. ST 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Wojciech Wojtczak

(a) RESIDENCE NO. 533 S Chapel St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	84			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 0 10

(b) General nature of industry, business, or establishment in which employed (or employer) Labor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Julia Wojtczak

(Address) 533 S Chapel St.

15 Filed MAY 6 1929, 19 C. HAMPSON JONES, M. D. Registrar

Per [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4 1929

17 I HEREBY CERTIFY, That I attended deceased from Apr 5, 19 29, to May 4, 19 29,

that I last saw he alive on May 4 19 29

and that death occurred, on the date stated above, at 5.55 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Urinary Bladder

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Paralysis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William Ry Davis M. D.

May 6 19 29 (Address) 836 N Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus May	8 1929
20 UNDERTAKER	ADDRESS
John M Weber & Co	Chester st

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45688 161-201 **E 45688**

CERTIFICATE OF DEATH

REGISTERED NO. .....

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 141 N Washington ST. 6-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James H Rideout

(a) RESIDENCE NO. 141 N Washington ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. 8 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Apr 29 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) 0-0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Howard Rideout

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hagerstown Md

12 MAIDEN NAME OF MOTHER Daisy Hardy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Edith Krabbe

(Address) 141 N Washington

15 MAY 7 1929 E. HARRISON JONES, M. D. *Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6-1929

17 I HEREBY CERTIFY, That I attended deceased from April 29 1929 to May 6 1929 that I last saw h alive on May 6 1929 and that death occurred, on the date stated above, at 5-55 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Inanition

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edmund P Harrison M. D.

19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Arlington Cem

DATE OF BURIAL May 7 1929

UNDERTAKER John Ulrich

ADDRESS Pulaski

Spec.—2-29-28—L. F. S.—500 Bks.

E 45689

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 24-001

E 45689

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 804 N. Parrish ST. (16-22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Flora Debery

(a) RESIDENCE NO. 804 N. Parrish ST., WARD 8. 6.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Col

5 ~~Single, Married, Widowed, or Divorced~~ (write the word): Widow

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of: Charles Debery

6 DATE OF BIRTH (month, day, and year): Unknown 1879

7 AGE — Years: 57 | Months | Days | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): S. C.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country):

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Jessie Debery

(Address) 2047 N. Parrish St

15 Filed 7 - 1929 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/5/29

17 I HEREBY CERTIFY, That I attended deceased from May 4, 1929, to May 5, 1929, that I last saw h[illegible] alive on May 5, 1929, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) B. H. Hatcher, M. D.

5/6, 1929 (Address) 1717 Pa Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Rockingham M.E. — DATE OF BURIAL: May 8 1929

20 UNDERTAKER: Sam'l. Clarke — ADDRESS: 140 Mosher

Spec.—2-29-28—L. F. S.—500 Blks.

E 45690

HEALTH DEPARTMENT—CITY OF BALTIMORE

151

CERTIFICATE OF DEATH

REGISTERED NO. E 45690

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1305 Druid Hill Ave. ST. 11-24 WARD)

2—FULL NAME James Ward Sr

(a) RESIDENCE NO. 1305 Druid Hill Ave ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Ward

6 DATE OF BIRTH (month, day, and year) March 7-1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	79	1	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Common Labor

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Accomac Va

PARENTS

10 NAME OF FATHER James Ward

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Ellen Palmer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mary E. Ward
(Address) 1305 Druid Hill Ave

15 5-7-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5, 1929.

17 I HEREBY CERTIFY, That I attended deceased from Jan. 18, 1929, to May 5, 1929 that I last saw h[illegible]ve on May 5, 1929 and that death occurred, on the date stated above, at 9.30 a.m.

The CAUSE OF DEATH* was as follows:

Uremic Toxemia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Gangrene of foot

(duration) yrs. 3 mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) John H. Lohmann M. D.

(Address) 1012 N. Lafayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem DATE OF BURIAL May 8th 1929

20 UNDERTAKER Chas. H. Case Son ADDRESS 1400 N. Mon

Spec.—1-10-21—M&T—1500 Bks.

E 45691 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 45691

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Franklin Square Hos. ST. 21 WARD

2-FULL NAME Baby Girl Rinker

(a) RESIDENCE NO. 2607 W. Fayette ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) May 6, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, 6 hrs. or min.
	✓	✓	✓	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md (State or country)

PARENTS

10 NAME OF FATHER Chester Raymond Rinker

11 BIRTHPLACE OF FATHER (city or town) Virginia (State or country)

12 MAIDEN NAME OF MOTHER Loose

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md

14 Informant Chester R. Rinker. (Address) 2607 W. Fayette St.

15 Filed 7-1929 19 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1929

17 I HEREBY CERTIFY, That I attended deceased from May 6, 1929, to May 6, 1929, that I last saw he alive on May 6, 1929, and that death occurred, on the date stated above, at 12.47 P. m.

The CAUSE OF DEATH* was as follows:

Accident of Pregnancy
Congenital Heart defect
Likely patent foramen ovale.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Atelectasis.

Congenital (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) James Bolton Marston M. D.

5-6-29 (Address) Medical Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Arnold Ridge DATE OF BURIAL May 7 1929

20 UNDERTAKER Chenoweth & Son ADDRESS 3617 Eastern Ave

CAUSE OF DEATH MUST BE FILLED IN BY PHYSICIAN. See instructions on back of certificates.

TION is very important.

Cor.—12-9-25—A Co.—200 Bks.

E 45692

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 45692

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 3518 Hecksher or St., 13 Ward)

2-FULL NAME Melorie J. Merryman

(a) RESIDENCE NO. 3518 Hecksher St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 29, 1929

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
			7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): md.

(State or country)

PARENTS

10 NAME OF FATHER Theodore Merryman

11 BIRTHPLACE OF FATHER (city or town): md.

(State or country)

12 MAIDEN NAME OF MOTHER Ethel Enson

13 BIRTHPLACE OF MOTHER (city or town): md.

(State or country)

14 Informant Ethel Merryman

(Address) 3518 Hecksher St.

15 Filed ..... 19 .....

Per ..... Registrar

C. HAMILTON JONES, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-6 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said Inquest

(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heart disease

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) John J. Morrissey, M. D.

(Coroner)

5/6, 1929 (Address) 7632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs., ... mos., ... ds. In the State ..... yrs., ... mos., ... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Hampden Date of Burial: May 7 1929

20 UNDERTAKER: Emerson Enson ADDRESS: 2415 Eastern Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

7

Cor.—10-16-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45693

1-PLACE OF DEATH

CERTIFICATE OF DEATH

90

E 45693

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of Baltimore: (No. 915 N. Washington St St., 7-13 Ward)

2-FULL NAME Hannah D. Hall

(a) RESIDENCE NO. 915 N. Washington St St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas J. Hall

6 DATE OF BIRTH (month, day, and year) July 15/1858

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	70	9	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Wm T. Fritz

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Dorothy Whittington

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Calvert Co. Md.

14 Informant Florence L. Schindler
(Address) [illegible] Washington St

15 Filed 10 [illegible] Registrar
7-1929 C. HANSON JONES, M. D.
Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an [illegible] (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) General Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature] M. D.

19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL May 7th 1929

20 UNDERTAKER George Schulling & Sons

ADDRESS 1126 E Hamburg

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45694 | CERTIFICATE OF DEATH | E 45694

185

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 203 N. Monroe ST., 20-7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emma M Soper

(a) RESIDENCE NO 2032 N. Monroe ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 7/12 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): April 3, 1862

7 AGE: Years 67 | Months 1 | Days 1 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: William Fowler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Elizabeth Solein

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Blanche Leonard

(Address) 2031 Monroe St

15 Filed 7-1929, 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5-4-29

17 I HEREBY CERTIFY That I attended deceased from Aug 6 '28, to May 4, 1929, that I last saw her alive on May 4, 1929 and that death occurred, on the date stated above, at 10 30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Cholitis following accidnt (Fractured R femur) nervous & mental Collapse

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Fractured R Surgical neck femur

(duration) yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death? Katz Grocery Store

Did an operation precede death? yes Date of Aug 8-1928

Was there an autopsy? Set Fracture no

What test confirmed diagnosis? Chronic Inflammation of Colon Blood & mucus

(Signed) Thos. H. Peck Jr. M. D.

5/6. 1929 (Address) 2300 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Conn	May 7 1929
20 UNDERTAKER	ADDRESS
Charles H Kechner	153 Hollins

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 45695

113 E 45695

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1516 Boyle St ST., 24 WARD)

2—FULL NAME Doris V. Schreiber

(a) RESIDENCE NO. 1516 Boyle St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 1 mos. 4 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Daughter

6 DATE OF BIRTH (month, day, and year): Dec 10 1927

7 AGE: 1 Years; Months 4 16; Days 24 26; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work:

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: William Schreiber

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Agnes Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Mrs Agnes Schreiber

(Address) 1516 Boyle St

15 Filed MAY 7-1929 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 6 1929

17 I HEREBY CERTIFY, That I attended deceased from Apr 29, 1929, to May 6, 1929, that I last saw h alive on May 6, 1929, and that death occurred, on the date stated above, at 2.30 p.m.

The CAUSE OF DEATH* was as follows:

Intestinal Toxemia, Enteritis (Pneumonia)

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Convulsions, Bronchopneumonia (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clin

(Signed) Wm Schaffer, M. D.

5/6, 1929 (Address) 1319 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet — DATE OF BURIAL: May 8 1929

20 UNDERTAKER: Chas. L. Stevens — ADDRESS: 1501 E Pratt Ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45696

181-001

E 45696

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of Baltimore: (No. 758 W. Hamburg St., 21-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bessie Megowen (McNeal) (Woolford)

(a) RESIDENCE NO. 758 W. Hamburg St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lester L. Megowen

6 DATE OF BIRTH (month, day, and year) May 14 - 1905

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	23	11	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER Wm. Woolford

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Margaret Rawlings

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Margaret Woolford
(Address) 614 Hanover St

15 Filed ..... 19 ..... HAMPSON JONES, M. D. Registrar

Y 7-1929 RMC

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

CO Poisoning. Illuminating Gas. Accidental death

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Tell Et ....., M. D.

5-7-. 1929. (Address) 2726 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross A A Co	5-8 1929
20 UNDERTAKER	ADDRESS
J Bernard E Hahn	1000 S Paca St

(OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

E 45697 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 45697

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instrad of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 529 N. Howard ST. 11-25 WARD)

2-FULL NAME Ethel T. Armacost

(a) RESIDENCE NO. 529 N. Howard ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 53 yrs. 9 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James G. Armacost

6 DATE OF BIRTH (month, day, and year) July 14-1875

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
53	9	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Wm D. Sparrow

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Wilhelmina Shawen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Leora H. Sparrow

(Address) 529 N. Howard St.

15 Filed MAY 7 1929 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6th 1929

17 I HEREBY CERTIFY, That I attended deceased from May 1st, 1929, to May 6th, 1929, that I last saw h. alive on May 6th, 1929, and that death occurred, on the date stated above, at 4. A. m.

The CAUSE OF DEATH* was as follows

Angina Pectoris

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thos. Maguire M. D.

M. 7, 1929 (Address) 14 E. Read St

*State the Disease Causing Death, or in deaths (from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery Co DATE OF BURIAL May 8 1929

20 UNDERTAKER Chas. E. Branch ADDRESS 802 Madison Ave

CAUTION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45698

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 ✓

REGISTERED NO. E 45698

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2002 Belair Rd ST., 8-16 WARD)

2—FULL NAME John G. Erdman

(a) RESIDENCE NO. 2002 Belair Rd ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 84 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mary J. Erdman

6 DATE OF BIRTH (month, day, and year) June 2/44

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	11	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Instalment Collector

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Frederick Erdman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Susan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mary J. Erdman

(Address) 2002 Belair road

Filed MAY-7-1929 CLAMPETT JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5/29

17 I HEREBY CERTIFY, That I attended deceased from Feb 21st, 1929, to May 5, 1929, that I last saw h[illegible] alive on May 5th 1929 and that death occurred, on the date stated above, at 5 35 P m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Arthur C Monninger M. D.

5-6, 1929 (Address) 323 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lyndm Pk

20 UNDERTAKER Philip Herring

DATE OF BURIAL May 6 1929

ADDRESS 2006 Belair

Spec.—2-29-28—L. F. S.—500 Bks.

Evelyn Endres 45699.

E 45699

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 45699

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE, (No. 204 S Chapel ST., 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Evelyn Endres

(a) RESIDENCE NO. 204 S Chapel ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 8 1928

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	11		23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None - W D

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Peter Endres

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Barbara Koelbel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Father

(Address) 204 S Chapel

15 Filed MAY [illegible] C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-6-29

17 I HEREBY CERTIFY, That I attended deceased from 5-5-29, to 5-6-29, that I last saw her alive on 5-6-29, and that death occurred, on the date stated above, at 1 A.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Acute Endocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Fred Brooks M. D.

(Address) 800 N Wolfe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Most Holy Redeemer	May 1929
20 UNDERTAKER	ADDRESS
Martin W. E. Dippeline	372 Ann St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45700

1—PLACE OF DEATH

CERTIFICATE OF DEATH

x 46

E 45700

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 1005 S. MOUNT ST. 19-28 (WARD)

2—FULL NAME NORA NEWMAN-BOWMAN

(a) RESIDENCE NO. 1005 S. MOUNT ST., WARD 9th

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Bowman

6 DATE OF BIRTH (month, day, and year): April 16th 1868

7 AGE: Years 61 | Months — | Days 19 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Lady Tailor

(b) General nature of industry, business, or establishment in which employed (or employer): 080

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Edward H. Bowman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Catherine H. Edwards

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

11 Informant: Mrs E. E. Kyard

(Address) 100 S. Mount St

15 Filed 7-1929, 19 Per C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 4th 29

17 I HEREBY CERTIFY, That I attended deceased from Jan 11, 1929, to May 4, 1929, that I last saw her alive on May 4, 1929, and that death occurred, on the date stated above, at 10:30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

(duration) yrs. mos. ds.

CONTRIBUTORY (secondary) Carcinoma of Uterus (duration) yrs. 10 mos. 15 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? History + findings

(Signed) James F. Cleary M. D.

5/6, 1929 (Address) 1724 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: May 10th 1929

20 UNDERTAKER: E. B. Phippet — ADDRESS: 1850 W Saratoga St

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45701

CERTIFICATE OF DEATH.

E 45701

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) 3724 (Street) Dunmore Ave (Ward) 27-56

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Overton

(a) RESIDENCE. No. 3724 Dunmore Ave ST., WARD. 27

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Colored	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Idella Overton

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hostler

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Idella Overton (Address) Near De Graw

15 Filed MAY 7-1929 19 HAMILTON JONES, M. D. Registrar. By JHA

THION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6th 1929

17

I HEREBY CERTIFY, That I attended deceased from May 4th 1929, to May 6th 1929, that I last saw h[illegible] alive on May 6th 1929, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis

(duration) 9 yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Alcoholism.

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Race Track.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Bolop M. D.

5/7. 1929 (Address) 592 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Charlottesville Va DATE OF BURIAL 5/7/29

20 UNDERTAKER Samuel G Hemsley ADDRESS 1701 McElderry

Spec.—2-29-28—L. F. S.—500 Bks.

45702

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

38

E 45702

1—PLACE OF DEATH Balto City Hospls — REGISTERED NO.

CITY OF BALTIMORE: (No. Balto Md ST., 7-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Saunders

(a) RESIDENCE NO. 617 W. Hoffman ST., 51 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eva Saunders

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 040

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER John Saunders

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Margaret Kendall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Balto City Hosps

(Address) Balto Md

15 Filed MAY 7-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-2-29

17 I HEREBY CERTIFY, That I attended deceased from 6-9-, 1927 to 5-2, 1929

that I last saw him alive on 5-2-, 1929

and that death occurred, on the date stated above, at 10.21 P. m.

The CAUSE OF DEATH* was as follows:

General Paralysis of Insane 6

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lueic Infection

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Serological & Clinical

(Signed) Nolan Krantz M. D.

5/2. 1929 (Address) Balto City Hospls.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem — DATE OF BURIAL 5/7 1929

UNDERTAKER Samuel J. Kennedy — ADDRESS Balto

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45703

CERTIFICATE OF DEATH. X 148

E 45703

REGISTERED NO.

1-PLACE OF DEATH Church Home & Infirmary

City of BALTIMORE: (No. 126 N. Broadway St. 6-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Ruth Berman

(a) RESIDENCE NO. 7603 8th St North West Washington D.C.

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. 1 mos. ds. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? 18 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Morris Berman

6 DATE OF BIRTH (month, day, and year) May 15- 1902

7 AGE

Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
24	11	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Russia

PARENTS

10 NAME OF FATHER Max Fradkin

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Russia

12 MAIDEN NAME OF MOTHER Rose Steiner

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Russia

14 Informant Morris Berman

(Address) Wash D.C

Filed MAY 7-1929 G. HAMPSON JONES, M. D. Registrar

Reg. 1007

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

May 6 1929.

17 I HEREBY CERTIFY, That I attended deceased from Apr 29, 1929, to May 6, 1929, that I last saw h[illegible] alive on May 6, 1929, and that death occurred, on the date stated above, at 10 10 P. m.

The CAUSE OF DEATH* was as follows:

Pyelo - Nephritis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Physical & Laboratory Findings

(Signed) D. Bloeser, M. D.

, 19 (Address) Church Home & Inform.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mt Carmel Date of Burial 5/7 19 29

20 UNDERTAKER Jack Levin ADDRESS 1439 E Balto St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45704

E 45704

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1007 N Fayette ST. 18-76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Hazel Blandon

(a) RESIDENCE NO. 1007 N Fayette ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Col.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 7, 1928

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	4	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Alexander Blandon

11 BIRTHPLACE OF FATHER (city or town) Anderson
(State or country) S. C.

12 MAIDEN NAME OF MOTHER Alvada Scott

13 BIRTHPLACE OF MOTHER (city or town) Anderson
(State or country) S. C.

14 Informant Alvada Blandon
(Address) 1007 N Fayette St

15 Filed ....., 19 C. HAMILTON JONES, M. D.
Registrar

VT-1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1929

17 I HEREBY CERTIFY, That I attended deceased from May 6, 1929, to May 6, 1929, that I last saw h alive on May 6, 1929 and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Laryngeal Spasm

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Norwood, M. D.

May 7 1929 (Address) 939 N Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	May 7, 1929
20 UNDERTAKER	ADDRESS 3?? N.
Mrs Kate R Williams	Schroeder St

Spec.—12-9-25—A Co.—200 Bks.

45705

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 45705
REGISTERED NO.

1-PLACE OF DEATH
City of BALTIMORE: (No. 1 Mc Tavish Ave. St. Violetville Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ethel Gray Bell

(a) RESIDENCE NO. Mc Tavish Ave. St. Violetville Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 Color or Race: White
5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Edward C. Bell

6 DATE OF BIRTH (month, day, and year): June 25-1906

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
22	10	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer,

9 BIRTHPLACE (city or town): Balto.
(State or country): Md.

PARENTS

10 NAME OF FATHER: Frederick C. Ames
11 BIRTHPLACE OF FATHER (city or town): Md.
(State or country)
12 MAIDEN NAME OF MOTHER: Alberta Hoffman
13 BIRTHPLACE OF MOTHER (city or town): Md.
(State or country)

14 Informant: Mrs. Alberta Ames
(Address) Mc Tavish Ave. Violetville

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 4th 1929

17 I HEREBY CERTIFY, That I attended deceased from June 15 1927 to May 4, 1929
that I last saw her alive on May 4, 1929,
and that death occurred, on the date stated above, at 12 30 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
(duration) 2 yrs. mos. ds.
CONTRIBUTORY (Secondary) Cardiac decompensation
(duration) yrs. 10 mos. ds.

18 Where was disease contracted if not at place of death? Same
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Cl. & Phy Exam
(Signed) Fred T. Kyper, M. D.
, 19 (Address) 3321 Frederick Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Park Cemetery
Date of Burial: May 7 1929
20 UNDERTAKER: George L. Schwab
ADDRESS: 1018 Druid Park Ave.

HAMPSON JONES, M. D.

MAY 7 1929

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45706

E 45706

CERTIFICATE OF DEATH.

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 216 S Augusta Av ST. 20-11 WARD)

2-FULL NAME Mrs Rosa Marie Dumler

(a) RESIDENCE No. 216 S. Augusta Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Dumler

6 DATE OF BIRTH (month, day, and year) Nov 5 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	67	6	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Rosemon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Eva Co

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr Joseph J. Dumler

(Address) 216 Augusta Ave

15 Filed MAY 1 - 1929 S. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29 19 29

17

I HEREBY CERTIFY, That I attended deceased from April 1, 19 29, to April 29, 19 29, that I last saw h alive on April 27, 19 29, and that death occurred, on the date stated above, at 10:10 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis Cardiac Stenosis, Chronic Nephritis Auto Intoxication

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Leonard J. McGrath, M. D.

, 19 29 (Address) 704 N. Carey St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL May 10 1929

20 UNDERTAKER Henry Hoerdt Sons, Inc. — ADDRESS 1301 E Eager St

Spec.–7-17-26—A Co.—200 Bks.

E 45707

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001

E 45707

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Maryland Lent Hosp. 1914 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kunigunda Miller.

(a) RESIDENCE NO. 1040 Sommerset St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Miller.

6 DATE OF BIRTH (month, day, and year): 10/11/1866

7 AGE: Years 62 Months 6 Days 24

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework.

(b) General nature of industry, business, or establishment in which employed (or employer): 237

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10 NAME OF FATHER: Conrad Mendrick

11 BIRTHPLACE OF FATHER (City or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Katherine

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Hospital Record

15 Filed 19 C. HAMILTON JONES, M. D. Registrar

7-1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: 5/5/29

17 I HEREBY CERTIFY, That I attended deceased from 4-5 . 19 29 to 5-5 . 19 29.

that I last saw h SR alive on 5-5 . 19 29.

and that death occurred, on the date stated above, at 12:40 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) 0 yrs. 0 mos. 30 ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia Cardiac Failure

(duration) 0 yrs. 0 mos. 15 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical.

(Signed) Thos. Thompson M. D.

19, 19 (Address) 757 Hollins St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — Date of Burial: May 8 1929

20 UNDERTAKER: Henry Foreck Sons, Inc. — ADDRESS: 1301 E Eager St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45708 E 45708

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 161 E Randall ST. 14-34 WARD 14

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah J Anderson

(a) RESIDENCE NO. 161 E Randall ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 79 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas J Anderson

6 DATE OF BIRTH (month, day, and year) Sept 16 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87	7	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework at home

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Levin Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Belle Zirkler

(Address) 232 E Monument St

15 Filed MAY 7 1929 19 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1929

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1929, to May 5, 1929, that I last saw h alive on May 5 1929 and that death occurred, on the date stated above, at 1 30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Ephemeritis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinically

(Signed) H. C. K. Campbell, M. D.

5/6, 1929 (Address) 1644 Linwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery — DATE OF BURIAL May 8 1929

20 UNDERTAKER John F. Denny — ADDRESS 715 Light St

TION IS very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45709

CERTIFICATE OF DEATH.

E 45709

169

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) Big Lake Druid Hill Park St., 13-69 Ward

2-FULL NAME Unknown

(a) RESIDENCE NO. Unknown St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

Cause 4/21/29.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M.

4 Color or Race C

5 Single, Married, Widowed, or Divorced, (write the word) —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE Years About 50 Months Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Unknown

PARENTS

10 NAME OF FATHER ✓

11 BIRTHPLACE OF FATHER (city or town) ✓

(State or country)

12 MAIDEN NAME OF MOTHER ✓

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant Police Dept

(Address) Police Dept

Filed MAY 7 - 1929, 19 C. HAMPSON JONES, M. D. Registrar

By _____

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Died 5/1, 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to _____ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning. Probably Suicide

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) John H. Mosser M. D. (Coroner)

5/5, 1929 (Address) 3602 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY. Date of Burial 19

20 UNDERTAKER Dept. of Health. ADDRESS MAY 7 - 1929

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

45710

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

185 E 45710

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Pronounced dead at St. Joseph Hospital St. 8-16 Ward)

2-FULL NAME J. Joseph Kuebel

(a) RESIDENCE NO. 2418 E. Lafayette Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 30/1893

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
35	35	11	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Construction for
(b) General nature of industry, business, or establishment in which employed (or employer) Refrigeratin Co
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Joseph A. Kuebel

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Lydia M. Kemp

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Joseph A. Kuebel
(Address) 2418 E. Lafayette Ave

15 Filed 7-1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Skull at base

Accidently fell on street

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Alcoholism

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Collins M. D.

5/7/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery

DATE OF BURIAL May 9, 1929

20 UNDERTAKER Robt L. Turnbull

ADDRESS 3142 N Broadway

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45711 HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 45711

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. 5-9 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rachael Thompson

(a) RESIDENCE NO. 1420 Mulligan ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nelson Thompson

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Chase Fuller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Records of

(Address) Baltimore City Hosp.

15 MAY 7-1929 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 9, 19 29, to May 6, 19 29, that I last saw her alive on May 6, 19 29 and that death occurred, on the date stated above, at 5:30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Myocardial Insufficiency

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis Physical Exam

(Signed) H. H. Jones, M. D.

19 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cemetery	May 9 1929
20 UNDERTAKER Chas. H. Johnson & Co.	ADDRESS N. Charles St.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

58-002

E 45712

CERTIFICATE OF DEATH

E 45712

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Mercy Hospital St. 27-42 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irene Meyers

(a) RESIDENCE NO. 2906 Willoy Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Apr 23 1903

7 AGE Years: 26 Months: Days: 13

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country): Maryland

PARENTS

10 NAME OF FATHER: Charles James

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Md

12 MAIDEN NAME OF MOTHER: Elizabeth Annie A Dance

13 BIRTHPLACE OF MOTHER (City or town):

(State or country): Maryland

14 Informant: Lloyd F Meyers

(Address): 2906 Willoy Ave

Filed 19 C. HAMPSON JONES, M. D.

Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/6/29 19

17 I HEREBY CERTIFY, That I attended deceased from 3/24/29, 19, to 5/6/29, 19,

that I last saw h r y alive on 5/6/29 19,

and that death occurred, on the date stated above, at 4 25 P.M. m.

The CAUSE OF DEATH* was as follows:

Splenic Anemia

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary): Gastric Hemorrhage

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) J. C. Winstead, M. D.

19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

Date of Burial: 5/9/29

20 UNDERTAKER: Emp A Farley Fulton & Haydte

Address

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AY 7-1929

Spec.—1-10-21—M&T—1500 Bks.

22434 ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 45713 — 33 E 45713

1-PLACE OF DEATH — REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 29 WARD)

2-FULL NAME Jeannette Collins

(a) RESIDENCE No. 1631 Mc Elderry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: B.

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1-10-1914

7 AGE — Years: 15 — Months: 3 — Days: 26, — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Zenobia Collins

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

15 7-1929 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1929

17 I HEREBY CERTIFY, That I attended deceased from April 19, 1929, to May 6, 1929, that I last saw her alive on May 6, 1929, and that death occurred, on the date stated above, at 12 15 A m.

The CAUSE OF DEATH* was as follows:

[redacted], Lungs, [redacted], Lymph Glands,

Tuberculosis of peritoneum

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Tuberculosis of Meninges

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? [redacted]

Did an operation precede death? [redacted] 3/29/29

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) [redacted], M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Leakey cem.

DATE OF BURIAL: May 8 1929

20 UNDERTAKER: Mrs J. G. Locke

ADDRESS: 1302 Jeffer

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45714

HEALTH DEPARTMENT—CITY OF BALTIMORE

111-001

CERTIFICATE OF DEATH

E 45714

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1512 W Lanvale ST., 16-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary F. Johnson

(a) RESIDENCE NO. 1512 W. Lanvale ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: C.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Scipio Johnson.

6 DATE OF BIRTH (month, day, and year): June 3, 1881

7 AGE: Years 47 48 | Months 11 | Days 2 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): At Home.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): St. Marys Co. Md.

PARENTS

10 NAME OF FATHER: John Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Charlotte Kelley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Scipio Johnson

(Address): 1512 W. Lanvale

15 Filed 7-7-1929 C. HAMPSON JONES, M. D. Registrar

By ....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 5, 1929.

17 I HEREBY CERTIFY, That I attended deceased from May 3, 1929, to May 5, 1929

that I last saw h alive on May 5 1929

and that death occurred, on the date stated above, at 7.45a. m.

The CAUSE OF DEATH* was as follows:

Ulcer of Stomach.

about

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary): Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. H. Pigott, M. D.

5/6, 1929 (Address) 1536 W. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Prot. Cathedral — DATE OF BURIAL: May 1929

20 UNDERTAKER: Wm. P. G. Elliott — ADDRESS: 1125 Eastlund

Spec.—2-29-28—L. F. S.—500 Bks.

E 45715

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 45715

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE (No. 521 Beaumont Ave ST., 19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Robert Wm White

(a) RESIDENCE NO. 521 Beaumont Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 66 yrs. 4 mos. 23 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice S. White

6 DATE OF BIRTH (month, day, and year) Dec 12, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	4	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Agent

(b) General nature of industry, business, or establishment in which employed (or employer) 01

(c) Name of employer Travellers Ins Co Balto Md.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Thomas White

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Margaret Phelps

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Alice S. White

(Address) 521 Beaumont Ave.

15 Filed 7-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1929

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1929, to May 5, 1929, that I last saw h[illegible] alive on May 5, 1929, and that death occurred, on the date stated above, at 4 P.M.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis, Ch Myocarditis, Ch Ad. Nephritis - Enlarged Prostate

(duration) 1+ yrs. mos. ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) [illegible], M. D.

May 6, 1929 (Address) 501 Johnston Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem

DATE OF BURIAL May 7, 1929

20 UNDERTAKER Wm Pickner & Sons

ADDRESS North & Pa

Spec.—2-29-28—L. F. S.—600 Bks.

E 45716

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

11-006

E 45716

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1736 Eastern ave ST. 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jennie J. Connolly

(a) RESIDENCE NO. 1736 Eastern ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John P. Connolly

6 DATE OF BIRTH (month, day, and year)

7 AGE: 67 Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: — Bongalasi

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs. Mollie Dolan
(Address) 403 S. Amity st

15 Filed 7-1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/6/29

17 I HEREBY CERTIFY, That I attended deceased from 4/29, 1929, to 5/6, 1929, that I last saw h alive on 5/5, 1929, and that death occurred, on the date stated above, at 12.45 P m.

The CAUSE OF DEATH* was as follows:

Influenza & Broncho Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary): Heart Failure & Arteriosclerosis

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy? —

What test confirmed diagnosis? Symptoms & symptoms

(Signed) Jay A Burlage, M. D.

19 (Address) 1623 E Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Vincent Cemetery — DATE OF BURIAL: May 8 1929

20 UNDERTAKER: William F. Schaeffer — ADDRESS: 1816 Monument

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45717 E 45717

CERTIFICATE OF DEATH

100-09

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSPITALS ST., 16-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Patrick Bowers

(a) RESIDENCE NO. Unknown ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records of

(Address) Baltimore City Hospitals

15 Filed 7-1929 C. HAMPSON JONES, M. D. Registrar

3555

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2, 1929

17 I HEREBY CERTIFY, That I attended deceased from September 18, 1925 to May 2, 1929, that I last saw him alive on May 2, 1929 and that death occurred, on the date stated above, at 2:30 A. m.

The CAUSE OF DEATH was as follows:

Senility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Probable Bronchopneumonia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) J. M. Hurt M. D.

, 19 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health.

ADDRESS MAY 7 - 1929

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45718 — **CERTIFICATE OF DEATH** — 31 — **E 45718**

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 2802 Louise Ave. ST. Hamilton WARD 24)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Kostens

(a) RESIDENCE NO. 2802 Louise Ave. ST. Hamilton WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine M. Kostens

6 DATE OF BIRTH (month, day, and year) Sept. 12th 1878

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
50	7	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B & O. R. R.

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Herman Kostens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Catherine M. Kostens

(Address) 2802 Louise Ave.

15 Filed 5-7-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6th 1929

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1926 to May 6, 1929, that I last saw h[im] alive on May 6, 1929 and that death occurred, on the date stated above, at 3:20 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic valvular heart disease

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Chas. Hulbert, M. D.

5/7, 1929 (Address) Maplewood & Belair Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Immanuel Cemetery	May 9 1929

20 UNDERTAKER Frederick Lassahn Sons ADDRESS Fullerton

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45719

E 45719

CERTIFICATE OF DEATH.

REGISTERED NO. 100

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 201 Franford St. (Ward) 26-41

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick Paul Haul

(a) RESIDENCE No. 201 Franford ave ST., Madeleny R.F.D. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Chas Haul

6 DATE OF BIRTH (month, day, and year): May 1866

7 AGE: Years 63 Months 2 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Homework

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country):

12 MAIDEN NAME OF MOTHER: not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant (Address): Chas Haul

15 7-1929 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5-5 1929

17 I HEREBY CERTIFY, That I attended deceased from May 3, 1929 to May 5, 1929

that I last saw her alive on , 1929,

and that death occurred, on the date stated above, at 0 m.

The CAUSE OF DEATH* was as follows: Bronchio Pneumonia

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas D Cosse, M. D.

19 (Address) Cosse & Southern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel Cemetery

DATE OF BURIAL: 5/8/29 19

20 UNDERTAKER: Young & Ruth

ADDRESS: 1735 Hoff

TION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45720

CERTIFICATE OF DEATH

129

E 45720

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS [redacted] REGISTERED NO.

CITY OF BALTIMORE: (No. [redacted] ST., 6-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Coxson

(a) RESIDENCE NO. 319 N. Dallas ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	53			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Perry Coxson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Martha Bayer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Records of
(Address) [redacted]

15 Filed MAY 7-1929 C. HAMPSON JONES, M. D. Registrar
By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 18, 1929 to May 2, 1929, that I last saw her alive on May 2, 1929 and that death occurred, on the date stated above, at 7 A. M. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? nw Date of

Was there an autopsy? nw

What test confirmed diagnosis? Laboratory

(Signed) [redacted] M. D.

, 19 (Address) BALTIMORE CITY HOSPITALS [redacted]

*State the Disease Causing Death, or in deaths due to external causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Agony Cemetery	5/7/29
20 UNDERTAKER George J. Ruth	ADDRESS 1735 Harford

Spec.—1-12-23—M&T—500 Bks.

E 4572

E 45721

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1200 E Lamar ST., 9-1 WARD)

2-FULL NAME William. E Ruddy.

(a) RESIDENCE NO. 1200. E. Lamar ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed, or Divorced~~, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret A. Ruddy.

6 DATE OF BIRTH (month, day, and year) Feb 18 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or ..... min
	54	2	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fermenting

(b) General nature of industry, business, or establishment in which employed (or employer) Klinchman

(c) Name of employer Frost Co

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Curtin Ruddy.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Ella Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Margaretha. Ruddy.

(Address) 1200 E. Lamar St

15 5-7-1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 19 29

17

I HEREBY CERTIFY, That I attended deceased from April 28, 1929, to May 5 19 29,

that I last saw h alive on May 5, 19 29

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis.

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Cancer

(duration) yrs mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas Crampton, M. D.

5/6, 19 29 (Address) 01 Lamar

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem.

DATE OF BURIAL 5/8/29 19

20 UNDERTAKER Geo L Ruddy

ADDRESS 1735 Hanford

TION is very important See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 45722

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49 Lo E 45722

REGISTERED NO.

1-PLACE OF DEATH Mt. St. Agnes College

City of BALTIMORE: (No. Mt Washington St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sister Margaret Mary Judge

(a) RESIDENCE NO. Mt St Agnes College St. Mt. Washington Ward

(Usual place of abode)

Length of residence in city or town where death occurred 76 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, ~~Married, Widowed,~~ or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Sept 9 1852

7 AGE Years: 76 Months: 1 Days: 28 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Religious 065

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Henry Judge

11 BIRTHPLACE OF FATHER (City or town) ? (State or country)

12 MAIDEN NAME OF MOTHER Susan ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country)

14 Informant Rev. Mother Carmelita (Address) Mt St Agnes.

15 MAY 7-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 May 7, 1929

17 I HEREBY CERTIFY, That I attended deceased from May, 1927 to May 7, 1929, that I last saw h[illegible] alive on May 4, 1929, and that death occurred, on the date stated above, at 8 PM.

The CAUSE OF DEATH* was as follows:

Bladder Carcinoma

Metastases to pelvis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & C

(Signed) H. R. Peters, M. D.

, 19 (Address) 1908 W Lexington St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Agnes Convent Cemetery — Date of Burial: May 8 1929

20 UNDERTAKER: Henry J. Jenkins Sons Co. — ADDRESS: Cathedral & Franklin St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45723

CERTIFICATE OF DEATH.

45

E 45723

1-PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2293 Mura St. 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George L Schoppert

(a) RESIDENCE. NO. 2233 Mura ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Stevens

6 DATE OF BIRTH (month, day, and year) Nov 10 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	5	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) Planing Factory

(c) Name of employer Morgan Mill Works

9 BIRTHPLACE (city or town) (State or country) W Va.

PARENTS

10 NAME OF FATHER Alexander Schoppert

11 BIRTHPLACE OF FATHER (city or town) (State or country) W Va.

12 MAIDEN NAME OF MOTHER Mary E Merchant

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W Va

14 Informant Mrs. G. L. Schoppert
(Address) 2233 Mura St.

15 Filed MAY 7-1929 C. HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5th 1929

17 I HEREBY CERTIFY, That I attended deceased from March 7 1929, to May 5 1929, that I last saw him alive on May 5 29 1929, and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Cancer intestine

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) None Given

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) C. H. Jones, M. D.

6/7, 1929 (Address) 2711 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Arbor Hill Cemetery — DATE OF BURIAL: 5/8/29

20 UNDERTAKER: E. J. Fanning store - 1736 — ADDRESS: E. Lafayette

TION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

JACOBS

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45724

CERTIFICATE OF DEATH

118-09

E 45724

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 19-28 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George J. Jacobs

(a) RESIDENCE NO. 1525 W. Pratt St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elsie A. Jacobs (nee Layman)

6 DATE OF BIRTH (month, day, and year) December 25, 1880

7 AGE Years 48 Months 4 Days 12 IF LESS than 1 day ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer United Railways Co

9 BIRTHPLACE (city or town)

(State or country) Md

PARENTS

10 NAME OF FATHER George J. Jacobs

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER Eliza Daisey

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Elsie A. Jacobs

(Address) 1525 W. Pratt St

15 Filed 7-1928 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/7/29 19

17 I HEREBY CERTIFY, That I attended deceased from 5/5/29, 19 to 5/7/29, 19

that I last saw h[illegible] alive on 5/7/29, 19

and that death occurred, on the date stated above, at 11:55 a.m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Myocarditis Fatty

(duration) yrs. mos. 1 da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of 5/5/29

Was there an autopsy?

What test confirmed diagnosis? Operation.

(Signed) [illegible], M. D.

. 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Date of Burial May 9 29

20 UNDERTAKER Harry A. Wirtz & Co ADDRESS 1531 W. Lombard St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

(Schreiner)

E 45725 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

12 E 45725

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1704 Cole (ST.) 14-28 (WARD)

2-FULL NAME Ann Agnes Schreiner see This

(a) RESIDENCE No. 1704 Cole St. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs. ... mos. ... ds. How long in U. S., If of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Adam Schreiner

6 DATE OF BIRTH (month, day, and year) Feb 17-1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ... min.
	78	2	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) — 37

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER See This

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Adam L. Schreiner

(Address) 1704 Cole St

15 C. HAMPSON JONES, M. D.

7-1929 D. H. SHOPPELL, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1929

17 I HEREBY CERTIFY, That I attended deceased from March 17, 1929, to May 5, 1929, that I last saw h... alive on May 4, 1929, and that death occurred, on the date stated above, at 12 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis - Arterio-

Sclerosis - Chronic Interstitial

Nephritis - Chronic

Interstitial (duration) ... yrs. 2 mos ... ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) ... yrs. ... mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of ...

Was there an autopsy? no

What test confirmed diagnosis? Signs of Pneumonia

(Signed) Thomas F. Kelly, M. D.

, 19 (Address) 904 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL May 8 1929

20 UNDERTAKER Harry N. Witzke — ADDRESS 1526 W. Fayette

Spec.—12 9 25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45726

CERTIFICATE OF DEATH.

11-001

E 45726

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2016 Wilhelm St., W 28 Ward 6

2-FULL NAME Kenneth E. Lewis

(a) RESIDENCE NO. 2016 Wilhelm St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 19 - 1928

7 AGE — Years: — Months: 10 Days: 17 IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.

(State or country) Md.

PARENTS

10 NAME OF FATHER William B. Lewis

11 BIRTHPLACE OF FATHER (city or town) ?

(State or country) Md.

12 MAIDEN NAME OF MOTHER Catherine Miller

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto. Md.

14 Informant William B. Lewis

(Address) 2016 Wilhelm St.

15 Filed May 7 1929 C. HAMPSON JONES, M. D. Registrar

7 - 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6th 1929

17 I HEREBY CERTIFY That I attended ~~deceased~~ from May 3rd, 1929 to May 6th, 1929, that I last saw ~~him~~ alive on May 6th, 1929, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia following influenza

(duration) ... yrs. ... mos. 1½ ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted? If not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) Otto Leibel M. D.

May 7, 1929 (Address) 1224-26 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Cemetery Date of Burial May 8 1929

20 UNDERTAKER: George L. Arbaugh ADDRESS 210 Fulton Ave.

OF DEATH in plain terms, so that it may be properly classified. Fatal diseases of occupation are very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Blks.

E 45727

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 45727

REGISTERED NO. 4434

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1718 Johnson St. 24 Ward)

2-FULL NAME Harry Irvin Peltzer

(a) RESIDENCE NO. 1718 Johnson St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. 6 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 30 1907

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	21	6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Inspector

(b) General nature of industry, business, or establishment in which employed (or employer) Locke Insulator Co.

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER Albert Peltzer

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Penn.

12 MAIDEN NAME OF MOTHER Mary Hodel

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore Md

14 Informant Albert Peltzer

(Address) 1718 Johnson

15 5-7-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 26 1928, to May 5, 1929,

that I last saw h~~e~~ alive on May 5, 1929,

and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. 4 mos. 10 ds.

CONTRIBITORY (Secondary) Epilepsy

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. K. Campbell, M. D.

5-7-1929 (Address) 1644 Harlem Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Ac Date of Burial 5/9 1929

20 UNDERTAKER J J Doherty & Sons ADDRESS 1318 Eutaw

OF DEATH in plain terms, so that no doubt of propriety, exactness, and very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 45728 HEALTH DEPARTMENT—CITY OF BALTIMORE E 45728

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1934 Mt Royal Terrace St. 14-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma J. Ash

(a) RESIDENCE NO. 1934 Mt Royal Terrace ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 90 yrs. 7 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	widowed

5a If [redacted], widowed, [redacted] (or) WIFE of James Ash.

6 DATE OF BIRTH (month, day, and year) Sept 12. 1838

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	90	7	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER George A. Spafford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Sarah Buck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant James A. Spafford

(Address) 2741 St Paul St.

15 Filed 7-1929 C. HAMPSON JONES, M. D. Registrar. Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7. 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1928. to May 6. 1929.

that I last saw h[redacted] alive on May 6. 1929,

and that death occurred, on the date stated above, at 2.00 A.M. m.

The CAUSE OF DEATH* was as follows:

Cardio-Vascular

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary edema

(duration) yrs. mos. 1 da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) W. M. Lore, M. D.

5/7, 1929 (Address) 836 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: May 8/29

20 UNDERTAKER: Hughes Funeral Home — ADDRESS: 424 N. Brdy.

TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 45729

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

CERTIFICATE OF DEATH

E 45729
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St. 25-75 Ward)

2-FULL NAME James F Floyd

(a) RESIDENCE NO. 3732 Brooklyn Ave. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 11- 1925

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	3	8	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER James A. Floyd

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Gertrude Bailey

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Mr James F Floyd
(Address) 3732 Brooklyn Ave

15 Filed ....., 19 W. H. HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 3732 Brooklyn Ave

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Feller M. D.

5/7/ 1929 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mar Hill

DATE OF BURIAL 5/9 1929

20 UNDERTAKER Wilson Cook

ADDRESS 1217 E Baltimore St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

Dr Montgatory 25 E Barclay St

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45730

CERTIFICATE OF DEATH

84 ✓ E 45730

1—PLACE OF DEATH

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 436 Whitridge ST., 12-50 WARD)

2—FULL NAME Maud C Robinson

(a) RESIDENCE NO. 436 Whitridge Ave ST., _____ WARD

(Usual place of abode)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (Write the word)
Female	White	Married.

6a If married, widowed, or divorced HUSBAND of (or) WIFE of George C Robinson

6 DATE OF BIRTH (month, day, and year) Feb 16, 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	56	2	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer) House work

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER James Wells

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Margret Rigger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Geo C Robinson

(Address) 436 Whitridge Ave

15 MAY 8 - 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 - 1929.

17 I HEREBY CERTIFY, That I attended deceased from April 20th, 1929, to May 6th, 1929

that I last saw her alive on May 5th, 1929

and that death occurred, on the date stated above, at 4.30 a m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos 18 ds.

CONTRIBUTORY (Secondary) _____

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Cadaveric Exam

(Signed) Geo Montgomery III M. D.

5/6, 1929 (Address) 401 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount	May 8 1929
20 UNDERTAKER William Cook	ADDRESS 1214 St Paul St

Spec.—1-12-23—M&T—500 Blks.

E 45731

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45731

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2609 Boone St 4-46 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie Scott

(a) RESIDENCE No. 2609 Boone St. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert Scott

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
45	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Hanover, Co. Va

PARENTS

10 NAME OF FATHER Anthony Waters

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Margaret Thames

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Robert Scott

(Address) 2609 Boone St

15 Filed ..... 19 .....

HARRISON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 16, 1928, to May 5, 1929.

that I last saw her alive on May 5, 1929

and that death occurred, on the date stated above, at a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

(duration) 2 yrs. 7 mos ? ds.

CONTRIBUTORY (Secondary) Senile Condition

(duration) yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) H. Hall, M. D.

19 (Address) 426 E 23 St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Calvary Cem	May 8 1929
20 UNDERTAKER John H. Goodman	ADDRESS 1027 Druid Hill

HON. is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45732

CERTIFICATE OF DEATH.

90 E 45732

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hosp. ST., 14-20 (WARD)

2-FULL NAME Mr. Geo. W. Fisher

(a) RESIDENCE NO. 1405 Linden Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna M. Fisher

6 DATE OF BIRTH (month, day, and year) Oct. 17-1857

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72	6	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Doctor

(b) General nature of industry, business, or establishment in which employed (or employer) General Practice

(c) Name of employer

9 BIRTHPLACE (city or town) Catawissa (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Hamilton Fisher

11 BIRTHPLACE OF FATHER (city or town) Catawissa (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Elizabeth Tapley

13 BIRTHPLACE OF MOTHER (city or town) Catawissa (State or country) Pennsylvania

14 Informant Robt. H. Fisher (Address) 2220 York Road (Lon)

15 Filed 5-9-1929 C. HARRISON JONES, M. D. Registrar

Per Dept

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/7 1929.

17 I HEREBY CERTIFY, That I attended deceased from 4/24, 1927, to 5/7, 1929, that I last saw h[illegible] alive on 5/7, 1929, and that death occurred, on the date stated above, at 4:30 A m.

The CAUSE OF DEATH* was as follows:

Cardiac failure

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary) Aortic & mitral insufficiency, arteriosclerosis. (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Physical exam.

(Signed) A. T. Silver, M. D.

19 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	May 9 1929

20 UNDERTAKER James B. Tyrer ADDRESS 1324 Eutaw Place

IMPORTANT. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45733 E 45733

CERTIFICATE OF DEATH.

57

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2111 Druid Hill Av ST. 14-59 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Harman

(a) RESIDENCE No. 2112 Druid Hill Av ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Henry B Harman

6 DATE OF BIRTH (month, day and year) Feb. 12 - 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	55	2	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Laurel Md

PARENTS

10 NAME OF FATHER Augustus Boyd

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Henry B Harman (Address) 2111 Druid Hill Ave

15 Filed MAY 6 1929 — 19 Per H. JAMESON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 19 29

17 I HEREBY CERTIFY, That I attended deceased from Feb 25, 19 29 to May 5, 19 29 that I last saw h alive on May 5, 19 29 and that death occurred, on the date stated above at 8 30 P m

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Ec Convulsions

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) T. B. Hughes, M. D.

May 6, 29 (Address) 1423 Druid Hill Ave

*State the Disease Causing Death, or if deaths from Violent state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem DATE OF BURIAL May 8 29

20 UNDERTAKER Samuel Hardy & Bro ADDRESS

TION is very important See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45734

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-002

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO. E 45734

CITY OF BALTIMORE: (No. 18-26 ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary A. Schaffinger (or Boehmer)

(a) RESIDENCE NO. 946 W. Lexington ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	~~Married~~ Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Janitor at

(c) Name of employer City School

9 BIRTHPLACE (city or town) City
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Records of
(Address) Baltimore City Hospitals

15 Filed MAY 8 1929 C. HARRISON JONES, M. D.
By Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6, 1929

17 I HEREBY CERTIFY, That I attended deceased from February 23, 1929, to May 6, 1929, that I last saw her alive on May 6, 1929, and that death occurred, on the date stated above, at 7:30 A m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Bronchitis, Emphysema (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) H. H. Stock, M. D.

, 19 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL W. A. Alvey — DATE OF BURIAL 5/10 1929

20 UNDERTAKER Philip Herring — ADDRESS 2016 Orleans St.

Spec.—1-10-21—M&T—1500 Bks.

E 45735 HEALTH DEPARTMENT—CITY OF BALTIMORE E 45735

CERTIFICATE OF DEATH. X 49

1-PLACE OF DEATH Sinai Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 713 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Herman Lefkowitz

(a) RESIDENCE NO. Orlando, Florida ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mollie Lefkowitz

6 DATE OF BIRTH (month, day, and year) 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	33	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Hyman Lefkowitz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Fannie Grotoretch

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Russia

14 Informant (Address) Jack Levis 1439 E. Baltimore St

15 Filed , 19 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/7 19 24

17

I HEREBY CERTIFY, That I attended deceased from May 5, 1924, to May 7, 1924, that I last saw him alive on May 7, 1924, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cancer of Thyroid Gland

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 5/6/24

Was there an autopsy? None

What test confirmed diagnosis? Physical Signs

(Signed) J. E. Gundrum, M. D.

5/7, 1924 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greensboro N.C DATE OF BURIAL 5/8 19 24

20 UNDERTAKER Jack Levis ADDRESS 1439 E. Baltimore St

MAY 8 1924 C. HAMPSON JONES, M.D. Registrar

CAUSES OF DEATH: See instructions on back of certificates. ATION is very important

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 45736

E 45736

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 105 N. Luzerne St., 6-10 Ward)

2-FULL NAME John G. Ziegler

(a) RESIDENCE NO. 105 N. Luzerne St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Lillian Gruber Ziegler

6 DATE OF BIRTH (month, day, and year) Mar 18/1885

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	44	1	19 18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Musician
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Mary Ziegler

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Ena Hronek

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto., Md.

14 Informant Mrs Lillian Ziegler
(Address) 105 N. Luzerne St.

15 Filed ... 19 ... HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6/29

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? History

(Signed) J. G. Ziegler, M. D.

5/7/29 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hagerstown Md

DATE OF BURIAL May 8 1929

20 UNDERTAKER John Ullrich

ADDRESS 208 Chase

OF DEATH in plain terms, so that it may be properly classified. Date statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 45737

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 E 45737

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1736 E. 22nd St. ST. 9-46 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Regrs.

(a) RESIDENCE NO. 1736 E. 22nd St. ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 1½ yrs mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White	married

5a If married, widowed, or divorced
~~HUSBAND of~~
~~(or) WIFE of~~
wife of Conrad Regrs.

6 DATE OF BIRTH (month, day, and year) Oct 24 - 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	5	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Ignatius Bonnett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Gertrude Loechte

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Conrad Regrs.
(Address) 1736 E. 22nd St

15 Filed ..... 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5 - 7 1929

17 I HEREBY CERTIFY, That I attended deceased from March 15 1929 to May 7 1929.
that I last saw her alive on May 4 1929,
and that death occurred, on the date stated above, at 9:15 a. m.
The CAUSE OF DEATH* was as follows:
Carcinoma of Liver.

(duration) ..... yrs. 6 mos ..... ds.
CONTRIBUTORY (Secondary) Cachexia. Metastasis.
(duration) ..... yrs. 1½ mos. ..... ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? [redacted] Date of [redacted]
Was there an autopsy? Yes 5 7 29
What test confirmed diagnosis?
(Signed) Chas Wallace Stewart, M. D.
5/7, 1929 (Address) 1728 E. 22nd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cem. DATE OF BURIAL May 10 1929

UNDERTAKER John Ellis & ADDRESS 240 E. Oliver

TION is very important. See instructions on back of certificates.

Y 8 - 1929

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45738

CERTIFICATE OF DEATH

113 E 45738

1—PLACE OF DEATH St Josephs Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. Caulens & Oliver ST. 12-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Bertha Harrison

(a) RESIDENCE NO. 2201 Barclay St ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mar 15

6 DATE OF BIRTH (month, day, and year) Jan 12-1929

7 AGE Years	Months 9	Days 27	If LESS than 1 day, hrs. or min.
	1	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) 2201 Barclay St Baltimore

PARENTS

10 NAME OF FATHER Phillip R Harrison

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Elena McCaffery

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Elena McCaffery

(Address) 2201 Barclayst

15 Filed [illegible] 19 C. HARRISON JONES, M. D. Registrar

Per [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/7/29

17 I HEREBY CERTIFY, That I attended deceased from 4/26, 1929, to 5/7, 1929, that I last saw h[illegible] alive on 5/7, 1929 and that death occurred, on the date stated above, at 8.45 P m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Enteritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) V. Messina, M. D.

St Josephs Hospital

*(State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	May 8 1929

20 UNDERTAKER Mary M. Wiedefeld ADDRESS 501 E 22nd St

Spec.—1-10-21—M&T—1500 Bks.

E ~~45739~~ 6 a m

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

33 E 45739

REGISTERED No.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles H Lewis

(a) RESIDENCE No. 946 Mason ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	black	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6-27-76

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	10	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 040

(b) General nature of industry, business, or establishment in which employed (or employer) Cutter

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER William

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Maria

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant (Address) JOHNS HOPKINS HOSPITAL

15 Filed MAY 8-1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1929

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1929, to May 5, 1929, that I last saw him alive on May 5, 1929, and that death occurred, on the date stated above, at 6 50 a m.

The CAUSE OF DEATH* was as follows:

T. B. Peritonitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia (duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Chas Briggs, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary DATE OF BURIAL May 8 1929

20 UNDERTAKER Robert E Williams ADDRESS 1515 McCulloh St

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Theresa Luzzi

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45740

161-001

E 45740

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 203 N. Bond ST. 5-8 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Theresa Luzzi

(a) RESIDENCE NO. 133 N. Bond ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of: Infant

6 DATE OF BIRTH (month, day, and year): April 25 1927

7 AGE: Years | Months | Days: 2 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Aldo Luzzi

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Adah Cabassi

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: Aldo Luzzi
(Address) 133 N. Bond St.

15 Filed 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/7/29

17

I HEREBY CERTIFY, That I attended deceased from April 25 1929, to May 7 1929, that I last saw h[illegible] alive on May 7 1929 and that death occurred, on the date stated above, at 2 10 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia - 6 mos ulcer

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Tuberculosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? Lung puncture

(Signed) Chas A Carl M. D.

5/7 1929 (Address) 2105 N Bolton St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer

DATE OF BURIAL: 5/8 1929

UNDERTAKER: Wendell & Dippel

ADDRESS: 300 S. Eden St

Spec.—2-29-28—L. F. S.—500 Blks.

E 45741

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 45741

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 7-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Williams

(a) RESIDENCE NO. 617 N Caroline ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred / yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Penna.

PARENTS

10 NAME OF FATHER Wallace Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna.

12 MAIDEN NAME OF MOTHER Jane Jordan

13 BIRTHPLACE OF MOTHER (city or town) Chicago (State or country) Ill.

14 Informant Records of

(Address) Balto. City Hosp.

15 Filed 5-8-1929 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 3, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 27, 1929, to May 3, 1929, that I last saw him alive on May 3, 1929 and that death occurred, on the date stated above, at 4:55 A m.

The CAUSE OF DEATH* was as follows:

Lobular Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Bronchiectasis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Exhibition & X Ray

(Signed) H. M. Hicks M. D.

, 19 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Evergreen Cemetery

DATE OF BURIAL May 8, 1929

20 UNDERTAKER Mrs Katie R. Williams

ADDRESS 322 N Schroeder St.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45742

CERTIFICATE OF DEATH.

100-001

E 45742
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 2410 St Paul St. 12-5 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Donaldson

(a) RESIDENCE NO. 2410 St Paul St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 Color or Race W

5 Single, Married, Widowed, or Divorced, (write the word) Widow

3a If married, widowed, or divorced HUSBAND of (or) WIFE of John F. Donaldson

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Pa

(State or country)

PARENTS

10 NAME OF FATHER Amos Bayshman

11 BIRTHPLACE OF FATHER (city or town) Pa

(State or country)

12 MAIDEN NAME OF MOTHER Julia Zeigler

13 BIRTHPLACE OF MOTHER (city or town) Pa

(State or country)

14 Informant Mrs. F. Whitelista

(Address) 335 Whitelock

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

May 7 - 1929

17

I HEREBY CERTIFY, That I attended deceased from May 3, 19 29, to May 7, 19 29, that I last saw h.. alive on May 7, 19 29, and that death occurred, on the date stated above, at 1615 a. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(also Bronchial asthma)

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) Myocardial Insuff.

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted

If not at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) S. W. Kouzey, M. D.

, 19 (Address) 1612 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Freedom Pa — Date of Burial 5/11 19 29

20 UNDERTAKER J. F. Sahay & Sons — ADDRESS 131 Zeigler Ave.

MAY 8 - 1929

OF DEATH in plain terms, so that it may be properly classified. Every statement is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45743

CERTIFICATE OF DEATH

44

E 45743

1—PLACE OF DEATH

REGISTERED NO. 16-37

CITY OF BALTIMORE: (No. 342 S. Newkirk ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Edward Reilly

(a) RESIDENCE NO. 342 S. Newkirk ST., 26 WARD
(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie L. Reilly

6 DATE OF BIRTH (month, day, and year) June 26th 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Inspector for Standard Gas Equip. Co.

(b) General nature of industry, business, or establishment in which employed (or employer) Gas Co. 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Newark N. J.

PARENTS

10 NAME OF FATHER John Reilly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Jane Dougherty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Jennie L. Reilly Wife

(Address) 342 Newkirk St.

15 Filed 1929, 19 H. HAMPSON JONES, M. D. Registrar

Y8-1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7th 1929

17 I HEREBY CERTIFY, That I attended deceased from March 1st, 1929, to May 7, 1929, that I last saw him alive on March 7th, 1929 and that death occurred, on the date stated above, at 5 30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Adam Ford, M. D.

, 19 (Address) 4700 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem. Brooklyn N. J.

DATE OF BURIAL May 9 1929.

20 UNDERTAKER Lilly & Sons Inc.

ADDRESS 4000 Wyoming Ave.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45744

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

+129 ✓

E 45744

1—PLACE OF DEATH BALTIMORE CITY

REGISTERED NO.

CITY OF BALTIMORE: (No. [redacted] ST. 16-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lizzie Jones

(a) RESIDENCE NO. 7212 Overbrook Rd. ST. WARD Catonsville, Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Adelbert Guild

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna.

12 MAIDEN NAME OF MOTHER Carrie Cole

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna.

14 Informant Records of

(Address) BALTIMORE CITY HOSPITALS

15 Filed [illegible] 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2, 1929

17 I HEREBY CERTIFY, That I attended deceased from January 15, 29, to May 2, 19 29, that I last saw her alive on May 2, 19 29 and that death occurred, on the date stated above, at 1:30 A.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Arteriosclerotic

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys & Laboratory

(Signed) J. M. Hicks M. D.

, 19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Calvary	May 5, 1929
20 UNDERTAKER Mrs. R. A. Elliott	ADDRESS 1725 Ashland Ave

5-8-1929 C. HARRISON JONES, M. D.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45745

CERTIFICATE OF DEATH

44

E 45745

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Balto. City Hosp. ST., 7-13 WARD)

2—FULL NAME Chas. Neal

(a) RESIDENCE NO. 618 N. Dallas St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) John Neal
(State or country) Frederick Maryland

PARENTS

10 NAME OF FATHER John Neal

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Louisa Spinner

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Mary Brooks
(Address) 618 N. Dallas St

15 Filed MAY 8 1929 G. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/7/29

17 I HEREBY CERTIFY, That I attended deceased from 4/15, 1929, to 5/7, 1929

that I last saw him alive on 5/7, 1929

and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

Metastasis to Liver

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchial pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical.

(Signed) H. C. Crumpaker, M. D.

5/7, 1929 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodbury cemetery	May 9 1929
20 UNDERTAKER Edward Bryan	ADDRESS 1631 Orleans St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45746

CERTIFICATE OF DEATH

16 2 ✓

E 45746

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 217 N. Chester ST., 6-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Lastner

(a) RESIDENCE NO. 217 Nelson ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed,~~ or ~~Divorced~~, (write the word)
Male	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 7-1924

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or 45 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Jno. Harold Lastner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Evelyn C. Kidder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mrs. Evelyn C. Lastner

(Address) 217 N. Chester

8-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7-1929

17

I HEREBY CERTIFY, That I attended deceased from 5-1, 19 29, to 5-7, 19 29, that I last saw him alive on 5-7, 19 29 and that death occurred, on the date stated above, at 10.45 P.m.

The CAUSE OF DEATH* was as follows:

Coryza ?

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward [illegible], M. D.

5-7, 19 29 (Address) 413 N. Wolfe St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	May 8 1929
20 UNDERTAKER Robt L Lamb	ADDRESS 1427 Pennsylvania

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

45747

CERTIFICATE OF DEATH.

129 E 45747

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 511 N. Fulton ave (ST.) (WARD)

2-FULL NAME Mary Rebecca Reed.

(a) RESIDENCE NO. 511 N. Fulton ave ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of The late John Franklin Reed

6 DATE OF BIRTH (month, day, and year) July about 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
About	73	10	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Annapolis (State or country) Md

PARENTS

10 NAME OF FATHER Geo. Davis

11 BIRTHPLACE OF FATHER (city or town) Annapolis (State or country) Md

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) Dont Know (State or country)

14 Informant John Franklin Reed (Address) 2005 Chelsea ave

15 Filed MAY 8 - 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6th 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 1st, 1928, to May 6 1929, that I last saw her alive on May 6 1929, and that death occurred, on the date stated above, at 11.15 P. m.

The CAUSE OF DEATH* was as follows:

Tertiary Syphilis

Nephritis - Arteriosclerosis

(duration) 6 yrs. 0 mos 0 ds.

CONTRIBUTORY (Secondary) Hypertension & Coronary Sclerosis

(duration) 0 yrs. 0 mos. 1 ds.

18 Where was disease contracted if not at place of death? Don't Know

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) F. R. Warner, M. D.

, 19 (Address) 1900 Reed St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.) None

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount — DATE OF BURIAL 5/9/1929

20 UNDERTAKER Geo. Weber & Son 2503 Eastern ave — ADDRESS Baltimore Md

TION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45748 HEALTH DEPARTMENT—CITY OF BALTIMORE 38

CERTIFICATE OF DEATH E 45748

1—PLACE OF DEATH Maryland Penitentiary Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 10-15 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Franklin

(a) RESIDENCE NO. Maryland Penitentiary ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. 26 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louise Carter

6 DATE OF BIRTH (month, day, and year) April 10, 1902

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	27		26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Edward Franklin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Rebecca Watts

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Albemarle Md.

14 Informant Wife (Address) 838 Edmondson Ave

15 Filed MAY 8-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6, 1929

17 I HEREBY CERTIFY, That I attended deceased from May, 1928, to May 6, 1929.

that I last saw him alive on May 6, 1929

and that death occurred, on the date stated above, at 12.30 p m.

The CAUSE OF DEATH* was as follows:

Syphilis Cardiovascular disease & Aortic Insufficiency

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Outside of Penitentiary.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas Wm Edmunds, M. D.

, 19 (Address) Md. Penitentiary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Calary Cemetery	5/8 1929
20 UNDERTAKER Walter B. Sprigg	ADDRESS 139 W. Hamburg St.

Spec.—2-29-28—L. F. S.—800 Bks.

Thiede ✓

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 45749 | 124 | E 45749

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3507 Plateau Ave. ST. 28-64 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Cresser Thiede

(a) RESIDENCE NO. 3507 Plateau Avenue ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Madeleine E. Thiede

6 DATE OF BIRTH (month, day, and year) Aug. 23, 1904

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24	8	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Baltimore & Ohio R.R. Co.

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Dr. Gustav A. Thiede

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER M. Mae Thiede

13 BIRTHPLACE OF MOTHER (city or town) Frederick
(State or country) Maryland

14 Informant Mrs. Madeleine E. Thiede
(Address) 3507 Plateau Avenue

15 Filed MAY 8 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6, 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 10, 1928, to May 6, 1929, that I last saw h im alive on May 6, 1929 and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Abscess Liver & Amebiasis
& Septicaemia

(duration) yrs. 5 mos. — ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes, Date of Jan 11-29

Was there an autopsy? no

What test confirmed diagnosis? Laboratory

(Signed) M B Baumann Lord, M. D.

5/7, 1929 (Address) 626 N. Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	May 9 19 29
20 UNDERTAKER Jos B Cook	ADDRESS 1003 West Baltimore St.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45750

CERTIFICATE OF DEATH

129 E 45750

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 9 Bedford Place ST. 27-49 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jesse L. Lewin

(a) RESIDENCE NO. 9 Bedford Place ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Georgie Lewin

6 DATE OF BIRTH (month, day, and year) July 24, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	9	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER William H. Lewin

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Katherine Smoot

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mr. Eldridge E. Donaldson

(Address) 9 Bedford Place

15 Filed MAY 8 - 1929, 19 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7, 1929

17 I HEREBY CERTIFY, That I attended deceased from ~~Oct~~ 1928, to May 7 1929, that I last saw him alive on May 6 1929, and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Heart failure Dropsy Pericardium

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis and dropsy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Howard L. Silver, M. D.

5/7, 19 29 (Address) 3706 Liberty Heights Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL May 10 19 29

20 UNDERTAKER Hartzell Cook

ADDRESS 1000 West Baltimore St.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45751

CERTIFICATE OF DEATH.

188-203

E 45751

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Agnes Hospital St. 25-72 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Dr. Arthur Williams

(a) RESIDENCE NO. Elkridge, Maryland St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? 55 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth B. Williams

6 DATE OF BIRTH (month, day, and year) July 7, 1852

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or....min.
	76	10	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician 054

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Davidsonville

(State or country) Anne Arundel County Maryland

PARENTS

10 NAME OF FATHER John W. Williams

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Anne Arundel County Maryland

12 MAIDEN NAME OF MOTHER Virginia Ann Igelhart

13 BIRTHPLACE OF MOTHER (city or town) Davidsonville

(State or country) Maryland

14 Informant Miss Helen L. Williams

(Address) Elkridge, Md.

MAY 8 1929 Filed 19 HAMILTON BOYD JONES, M. D. City Registrar

Mar Rak

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Automobile accident
Fracture Skull

(duration) yrs. mos. 0 ds.

CONTRIBUTORY (secondary)

(duration) yrs. mos. ds.

(Signed) Chas. H. Bramble M. D.

(Coroner) S. W. Gen

May 7. 1929 (Address) 3601 Third Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery Date of Burial May 10 1929

20 UNDERTAKER A. J. Beck ADDRESS 1003 West Baltimore St.

OF DEATH in plain terms, so that it may be properly classified. Every certificate is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 45752 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. X 29 E 45752

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Womans Hospital

CITY OF BALTIMORE: (No. ..... ST., 14-20 WARD)

2-FULL NAME Minna Hoen Thomas

(a) RESIDENCE NO. Hyde Balto Co Md. ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred life mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Albert Lewis Thomas

6 DATE OF BIRTH (month, day, and year) Sept 5 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
51	51	8	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) -

(c) Name of employer -

9 BIRTHPLACE (city or town) (State or country) Balto md.

PARENTS

10 NAME OF FATHER John Herman Muller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bremen Germany

12 MAIDEN NAME OF MOTHER Josefine Hoen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto md.

14 Informant Husband.
(Address)

15 FILED MAY 8 - 1929. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May - 8 - 1929

17

I HEREBY CERTIFY, That I attended deceased from May - 6, 1929, to May 8, 1929, that I last saw h[illegible] alive on May 8, 1929, and that death occurred, on the date stated above, at 10 30 A m.

The CAUSE OF DEATH* was as follows:

Tetanus - following injury to foot on April 25-1929 (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Respiratory failure (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Earle P. Clemm M. D.

, 19 (Address) Womans Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Johns R C — DATE OF BURIAL May 10 1929

20 UNDERTAKER John E. Slade — ADDRESS Long Green Md

CAUSE OF DEATH must be plainly written. See that no abbreviations are used. ATTENTION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. S.—500 Bks.

Back - 1206 N Carlton

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45753

CERTIFICATE OF DEATH

47

REGISTERED NO. E 45753

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 137 Augusta ST., 58 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Blanche Keyser

(a) RESIDENCE NO. 137 Augusta ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred ~~yrs.~~ mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles

6 DATE OF BIRTH (month, day, and year) April 12 85

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45		25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Charles Keyser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Anna Frick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Chas. Keyser
(Address) 137 Augusta St

15 [illegible] C. HAMPSON JONES, M. D.
Registrar

MAY 8 - 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7, 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1929, to May 1929, that I last saw her alive on May 4 1929 and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Lungs
metastasis from Breast

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Frederick D. Mack, M. D.

19 (Address) 927 N Charles St Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Md

DATE OF BURIAL 5 1929

20 UNDERTAKER J. M. Cook

ADDRESS Park Ave & Saratoga St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45754 ✓ E 45754

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 102 N. Carlton ST. 18-16 WARD) REGISTERED NO. 162

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rosa May Lyle

(a) RESIDENCE NO. 102 N. Carlton ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): May 8th 29

7 AGE	Years	Months	Days	If LESS than 1 day, ? hrs. or min.
—	—	—	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto City

PARENTS

10 NAME OF FATHER: Edward Lyle

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Susie Saunders

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Edward Lyle
(Address) 102 N. Carlton st

15 Filed 8-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/8/29

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1929, to May 8, 1929, that I last saw h[illegible] alive on May 8, 1929 and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Atelectasis 2 hours
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. H. Hatch, M. D.
5/8, 1929 (Address) 1111 Pa Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: May 8 1929

20 UNDERTAKER: H. E. Jones

ADDRESS: N. Gilmor

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45755

99-802

E 45755

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Sumwalt

(a) RESIDENCE NO. 125 N. Exeter ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Sumwalt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Walton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Records of
(Address) Baltimore City Hospitals

15 MAY 8 - 1929, 19 C. HAMPSON JONES, M. D. Registrar

335 ARD

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5, 1929

17 I HEREBY CERTIFY, That I attended deceased from January 2, 1929, to May 5, 1929, that I last saw him alive on May 5, 1929 and that death occurred, on the date stated above, at 5:30 A m.

The CAUSE OF DEATH* was as follows: Hypertrophy of Prostate, Ureteritis, Obstructive

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Chr. Bronchitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no - Refused Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) M. D.

, 19 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

UNIVERSITY OF MARYLAND

Commissioner Health

MAY 8 - 1929

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45756

CERTIFICATE OF DEATH.

91-08 V

E 45756

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1712 Clarkson ST., 23 32 WARD)

2-FULL NAME Mary C. Eyer

(a) RESIDENCE NO. 1712 Clarkson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [redacted] yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Eyer

6 DATE OF BIRTH (month, day, and year): April 3/1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or .... min.
	76	1	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mr. S. Eyer

(Address): 1712 Clarkson

15 8-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 7 1929

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1929, to May 7, 1929, that I last saw h[illegible]live on May 7, 1929, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Uterine Cancer

1 Indefinite (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) T. K. E. Campbell M. D.

5/7, 1929 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cem

DATE OF BURIAL: 5/8, 1929

20 UNDERTAKER: Fredk C Cole

ADDRESS: 1616 W Baltimore

TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 45757

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

92 E 45757

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Enroute to

City of Baltimore: (No. Johns Hopkins Hospital St., 9-14 Ward)

2-FULL NAME Henry Ford

(a) RESIDENCE NO. 1613 Latrobe St St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	black	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Mary Ford

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
about 50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) C & P Telephone Co

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Charlotte Co., Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

14 Informant Henrietta Ford (Daughter)

(Address) 210 W 131 St., New York

15 Filed 5-8-1929 C. HAMPSON JONES, M. D. Registrar

By ____

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Coronary Arterial Thronbosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? At Hopkins Hospital

What test confirmed diagnosis?

(Signed) J. S. Ravenel, M. D.

5/8/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cemetery — DATE OF BURIAL May 9 1929

20 UNDERTAKER Adolphus Dalstead — ADDRESS 904 N Eutaw

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45758 E 45758

CERTIFICATE OF DEATH.

185

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2119 Homewood Ave. 9-46 WARD)

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miranda Ann Vickers

(a) RESIDENCE. No. 2119 Homewood Ave 9 WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced (HUSBAND of) (or) WIFE of James Edward Vickers (deceased)

6 DATE OF BIRTH (month, day, and year) Mar. 1. 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Sussex Co. Delaware

PARENTS

10 NAME OF FATHER Noah Cooper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Delaware, U.S.A.

12 MAIDEN NAME OF MOTHER Mary Ann Messick

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Delaware U.S.A.

14 Informant Ada V. Vickers (Address) 2119 Homewood Ave

15 Filed 8-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 17, 1929. to May 7, 1929 that I last saw her alive on May 7th, 1929. and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Acute Pyelitis (Cause)

(duration) 0 yrs. 0 mos. 14 ds.

CONTRIBUTORY (Secondary) Impacted Fracture of Femur

(duration) 0 yrs. 0 mos. 21 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) Gustavus E. Dohme M. D.

5/7/ 1929 (Address) 3014 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Green Mount Cemetery May-10 1929

20 UNDERTAKER — ADDRESS

Stewart & Co. Balto

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45759

HEALTH DEPARTMENT—CITY OF BALTIMORE

86-001

E 45759

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3705 Dorchester Road ST. 07-36 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Estella Belle Haines

(a) RESIDENCE NO. 3705 Dorchester Road ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. 0 mos. 0 ds. How long in U. S., if foreign birth? 36 yrs. 1 mos. 22 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

..a If married, widowed, or divorced HUSBAND of (or) WIFE of George H. Haines

6 DATE OF BIRTH (month, day, and year) Mar-14-1893

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	36	1	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Frederick Co. (State or country) Maryland

PARENTS

10 NAME OF FATHER John E. Wilhide

11 BIRTHPLACE OF FATHER (city or town) Frederick Co. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Alice B. Miller

13 BIRTHPLACE OF MOTHER (city or town) Frederick Co. (State or country) Maryland

14

Informant Mr. George H. Haines (husband)

(Address) 3705 Dorchester Road

15

Filed 8-1929

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6th, 1929

17

I HEREBY CERTIFY, That I attended deceased from May 4th, 1929, to May 6th, 1929,

that I last saw her alive on May 5th, 1929

and that death occurred, on the date stated above, at 6:15 A. m.

The CAUSE OF DEATH* was as follows:

Septic Coronary Embolus

sudden (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Otitis Media (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? --

Did an operation precede death? Yes Date of May 5th, 1929

Was there an autopsy? No

What test confirmed diagnosis? Physical diagnosis

(Signed) [signature] M. D.

5/6/29 19 (Address) 1901 Eutaw Place, City.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	May-9-29 19
20 UNDERTAKER	ADDRESS
Stewart Mortuary Co	Balto

Spec.—2-29-28—L. F. S.—500 Bks.

E 45760 HEALTH DEPARTMENT—CITY OF BALTIMORE **E 45760**

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1702 Holbrook ST., 9-18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Michael Byrne

(a) RESIDENCE NO. 1702 Holbrook ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. 0 mos. 0 ds. How long in U. S., if foreign birth? 50 yrs. 0 mos. 0 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): October-15-1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	6	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Letter Carrier

(b) General nature of industry, business, or establishment in which employed (or employer): Letters

(c) Name of employer: U.S.Government

9 BIRTHPLACE (city or town) (State or country): Liverpool, England

PARENTS

10 NAME OF FATHER: Hugh Byrne

11 BIRTHPLACE OF FATHER (city or town) (State or country): ? ? Ireland

12 MAIDEN NAME OF MOTHER: Julia Breslin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ? ? Ireland

14 Informant: Mrs. Margaret McNally

(Address) 518 E. Eager Street

15 Filed 8-1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 6th 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 2nd, 1929, to May 6th, 1929, that I last saw h[illegible] alive on May 6th, 1929 and that death occurred, on the date stated above, at 4:30 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary): Ascites

(duration) — yrs. 2 mos. 0 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) Jefferies Bunck, M. D.

5/8, 19[illegible] (Address) 24 W. 5 Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	May-9-29 19
20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM P. MOWEN, Successor)	ADDRESS: 108 W. NORTH

Spec.—2-29-28—L. F. S.—500 Bks.

E 45761

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 45761

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1023 Vincent St. 16-22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph Branch

(a) RESIDENCE NO. 1023 Vincent ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Hattie Branch.

6 DATE OF BIRTH (month, day, and year) — 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Hattie Branch

(Address) 1023 N. Vincent

15 Filed MAY 8-1929, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5. 1929

17 I HEREBY CERTIFY, That I attended deceased from March 1, 19 29, to May 5, 19 29, that I last saw h[illegible] alive on May 7, 19 29 and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. mos. 0 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did operation precede death? Date of

Was there an autopsy?

What was confirmed diagnosis?

(Signed) P. H. Hateley, M. D.

5/8, 19 29 (Address) 1215 Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery — DATE OF BURIAL May 9 1929

20 UNDERTAKER Thomas E. Kelson — ADDRESS 1303 Pennsylvania Ave

Spec.—2-29-28—L. F. S.—500 Bks.

E 45762

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

32 E 45762

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE: (No. [redacted] ST., 7-27 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Albert Davis

(a) RESIDENCE NO. 739 Eisley ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not obtained

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER George

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Lanier

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Patients record

(Address) BALTIMORE CITY HOSPITALS

15 Filed 5-8-1929, 19 [redacted] Registrar

E. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-4-29

17 I HEREBY CERTIFY, That I attended deceased from 4-29, 19 29, to 5-4, 19 29, that I last saw him alive on 5-4, 19 29, and that death occurred, on the date stated above, at 8:00 P. m.

The CAUSE OF DEATH* was as follows:

Meningitis, tuberculous

CONTRIBUTORY (Secondary) (duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Laboratory

(Signed) H. H. Hecht, M. D.

(Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL May 9 1929

20 UNDERTAKER Thomas E. Kelson.

ADDRESS 1303 Presstman St

Spec.—1-10-21—M&T—1500 Bks.

E 45763 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 45763

REGISTERED NO. 101-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1804-N. Broadway (ST.) E-1 (WARD)

2-FULL NAME Celeste M. Drohan

(a) RESIDENCE NO. 1804-N. Broadway ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1-15-1882

7 AGE — Years: 47 Months: 3 Days: 22 If LESS than 1 day: X hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Saleslady

(b) General nature of industry, business, or establishment in which employed (or employer): Dept X. Store

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: David Drohan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Mary Roach

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Mrs. Chas. Steinmetz (Address) 1804-N Broadway

15 Filed: 19 By: C. HAMPSON JONES, M. D. Registrar

MAY 9 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 8 1929

17 I HEREBY CERTIFY, That I attended deceased from April 24, 1929, to May 7, 1929, that I last saw h[illegible] alive on May 7, 1929, and that death occurred, on the date stated above, at 12 45 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia Bilateral

Pastic Pleurisy left

(duration) yrs. mos 11 ds.

CONTRIBUTORY (Secondary) Myocardial Insuff.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C. W. Bowers M. D.

19 (Address) 612 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem. DATE OF BURIAL: 5/10/29

20 UNDERTAKER: Geo. J. Nutta ADDRESS: 1735 Harford Ave

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 45764 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 45764

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2013 Cedley St. (05-32 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas J McKay.

(a) RESIDENCE NO. 2013 Cedley St., (West po[illegible] WARD)

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 23 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	5	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Thomas McKay.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Leary

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Mary McKay

(Address) 2013 Cedley St

15 Filed MAY 9-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1929

17

I HEREBY CERTIFY, That I attended deceased from April 14, 1929, to May 7, 1929, that I last saw h[illegible] alive on May 7, 1929, and that death occurred, on the date stated above, at 10:10 p. m.

The CAUSE OF DEATH* was as follows:

Hypertrophied cardis

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Acute Dilatation of heart (duration) [illegible] yrs. [illegible] mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Heart sounds

(Signed) Raymond V. Thomas, M. D.

8, 1929 (Address) Fallsland

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral. DATE OF BURIAL 5-11 1929

20 UNDERTAKER Bernard C Harle ADDRESS 1000 Park Ave

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45765

CERTIFICATE OF DEATH

100-001

E 45765

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 1133 Battery Ave St. 24-23 WARD)

2—FULL NAME Frank G. Waltenspier

(a) RESIDENCE NO. 1133 Battery Ave St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Ida Waltenspier

6 DATE OF BIRTH (month, day, and year) Oct 4 1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	7	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman. 066

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Geo Waltenspier

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Mary Gallagher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Ida Waltenspier

(Address) 1133 Battery Ave

15 Filed 9-1929, 19 C. HAMPSON GILES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-7-29

17 I HEREBY CERTIFY, That I attended deceased from May 6, 1929 to May 7, 1929

that I last saw h alive on May 7, 1929

and that death occurred, on the date stated above, at 10:20 A m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

Primary

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory - microscopic

(Signed) J. A. Schumann, M. D.

19 (Address) 1337 S. Wash Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Q & Co.	5-10 19 29
20 UNDERTAKER	ADDRESS
E & B Hank	115 S West St

Spec.—2-29-28—L. F. S.—500 Bks.

E 45766

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 45766

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. ..... ST., 5-8 WARD) REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Beste

(a) RESIDENCE NO. 209 N. High ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer) 01

(c) Name of employer .....

9 BIRTHPLACE (city or town) Maryland
(State or country)

PARENTS

10 NAME OF FATHER Herman Beste

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Maryland

14

Informant Records of

(Address) Baltimore City Hospitals

15

Filed ....., 19 HAMPSON [illegible] M. [illegible]

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7, 1929

17

I HEREBY CERTIFY, That I attended deceased from March 23, 19 29, to May 7, 19 29, that I last saw h[illegible] alive on May 7, 19 29 and that death occurred, on the date stated above, at 8:50 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
Infarcts of Lungs and
Brain -

..... (duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) Harris M McClain, M. D.

, 19 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore

DATE OF BURIAL [illegible] 19 29

20 UNDERTAKER W. Cook

ADDRESS 1217 E Pratt St

Spec.—2-29-28—L. F. S.—500 Bks.

Dr Glassman
1748 W Fayette St.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45767

CERTIFICATE OF DEATH

E 45767

1—PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1533 Appleton ST. 16-27 WARD)

2—FULL NAME Rhoda Belle Williams

(a) RESIDENCE NO. 1533 Appleton ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married.

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Raymond Williams

6 DATE OF BIRTH (month, day, and year) Aug 5th 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	35	9	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Franklin Co Pa

PARENTS

10 NAME OF FATHER Jacob A Bush.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Franklin Co Pa

12 MAIDEN NAME OF MOTHER Mary C Phiel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Franklin Co Pa

14 Informant Carrie Waddell

(Address) 1533 Appleton St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 - 1929.

17 I HEREBY CERTIFY, That I attended deceased from Jan 1929, to May 7 1929.

that I last saw her alive on May 7, 1929

and that death occurred, on the date stated above, at 8 30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

(doration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Feb 1929

Was there an autopsy? Not

What test confirmed diagnosis?

(Signed) Henry Glassman, M. D.

May 8 19 29 (Address) 3601 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Work Springs Pa

DATE OF BURIAL 5/10 1929

20 UNDERTAKER Wm Cook

ADDRESS 1217 Lemmon St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45768

CERTIFICATE OF DEATH

E 45768

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Saint Joseph's Hospital (WARD) REGISTERED NO. 4754

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mamie Franks.

(a) RESIDENCE NO. 3724 Northern Pky ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel S. Franks

6 DATE OF BIRTH (month, day, and year) Nov 11. 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	5	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Newton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt Md

12 MAIDEN NAME OF MOTHER Katherine Erdman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Samuel S Franks

(Address) 3724 Northern Parkway

15 Filed MAY 9 - 1929 WILLIAM S. SIMMONS, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/8/29

17 I HEREBY CERTIFY, That I attended deceased from 5/2, 1929, to 5/8, 1929, that I last saw h alive on 5/8, 1929, and that death occurred, on the date stated above, at 6.45 A m.

The CAUSE OF DEATH* was as follows:

Cholecystitis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of 5/3/29

Was there an autopsy? no Manning Yes Walker

What test confirmed diagnosis? Clinical

(Signed) W B Hunting, M. D.

. 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood	5 11 1929
20 UNDERTAKER W. C. Cook	ADDRESS 1217 W Fayette St

Spec.—2-29-28—L. F. S.—500 Bks.

E 45769

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

111-001

E 45769

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. So. Balto. Gen. 2424 ST. WARD)

2—FULL NAME Harry Eaton

(a) RESIDENCE NO. 671 Clement ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillie M Eaton

6 DATE OF BIRTH (month, day, and year) Jan 27 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48 yrs	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Eaton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Alberta Burns

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Lillie Eaton

(Address) 671 E. Clement St

15 Filed ....., 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1929.

17 I HEREBY CERTIFY, That I attended deceased from May 6, 1929, to May 7, 1929, that I last saw him alive on May 7, 1929 and that death occurred, on the date stated above, at 8 P.M.

The CAUSE OF DEATH* was as follows:

Perforated Gastric Ulcer

4 hours (duration) ....yrs....mos....ds.

CONTRIBUTORY (Secondary) Aspiration Pneumonia of both lungs (duration) ....yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? City

Did an operation precede death? Yes Date of May 6, 1929

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) E. A. Pilsinger, M. D.

, 19 (Address) 1213 Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Hill — DATE OF BURIAL 5/10 1929

20 UNDERTAKER Wilson Cook — ADDRESS 1217 E Cold St

Spec.—2-29-28—L. F. S.—500 Bks.

E 45770

HEALTH DEPARTMENT—CITY OF BALTIMORE

46 E 45770

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Balto. City Hosp ST. 17-76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emma Ophai

(a) RESIDENCE NO. 506 N. Pine ST ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) MARCH 15, 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work HOUSEWORK

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Fredericksburg Va (State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) UNKNOWN

12 MAIDEN NAME OF MOTHER UNKNOWN

13 BIRTHPLACE OF MOTHER (city or town) (State or country) UNKNOWN

14 Informant MAMIE LUCAS

(Address) 506 N Pine ST

15 Filed MAY 4 - 1929 19 HAMILTON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/6/29

17 I HEREBY CERTIFY, That I attended deceased from 4/29, 1929, to 5/6, 1929, that I last saw h.c.r. alive on 5/6/29, 19 and that death occurred, on the date stated above, at 1:30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma Uterus

Decubitus ulcers of back

(duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. M. Lumpkin, M. D.

5/7, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	May 9 1929
20 UNDERTAKER	ADDRESS
Theodore H White	112 S Fremont

Cor.—10-10-29—A Co.—100 Bks.

E 45771

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

188-103

E 45771

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Sinai Hospital St. 13-59 Ward)

2-FULL NAME Eva Deckerman

(a) RESIDENCE NO. 2009 Orem Ave St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Jacob Deckerman

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	80			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Wm. A. Deckerman
(Address) Plymouth Hall Apartments

15 Filed MAY 9 - 1929 HAMILTON JONES, M. D. Registrar
By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pneumonia (terminal)

(Accidently struck by autom bile Eutaw Pl & Brooks Lane Mar 5/29)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Jos. H. Button, M. D.

5/9/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Hebrew. DATE OF BURIAL 5/9 1929

20 UNDERTAKER Jack Lewis ADDRESS 1434 E Balto

Spec.—1-10-21—M&T—1500 Blks.

E 45772 ~~E 48440-7~~ HEALTH DEPARTMENT—CITY OF BALTIMORE E 45772

CERTIFICATE OF DEATH.

135

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 7-10 WARD)

2-FULL NAME George Huber

(a) RESIDENCE NO. 6-10 N-Rose ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ——

6 DATE OF BIRTH (month, day, and year) Sept 24/1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	7	13	

8 OCCUPATION OF DECEASED Laborer.

(a) Trade, profession or particular kind of work Ice Plant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md —

PARENTS

10 NAME OF FATHER George Huber

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sophie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

MAY 9 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1929

17

I HEREBY CERTIFY, That I attended deceased from Apr. 16, 1929. to May 6, 1929.

that I last saw h alive on May 6, 1929.

and that death occurred, on the date stated above, at 12 24 p m.

The CAUSE OF DEATH* was as follows:

Pyelonephritis

Uremia

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Benign Prostatic Hypertrophy (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) H C Smith, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
1st German Evangelical Cem	May 9 1929
UNDERTAKER	ADDRESS
Geo C Miller & Son	2334 Jeffer 11

TION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45773

E 45773

CERTIFICATE OF DEATH.

167-00

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3302 Ruckert Ave. St. 27-44 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME HENRY HANAUER

(a) RESIDENCE NO. 3302 Ruckert Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katherine J. Hanauer

6 DATE OF BIRTH (month, day, and year) October 24, 1872

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	56	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher 013

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Broadway Abbatoir

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Hanauer

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Katherine Burk

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs. Katherine J. Hanauer (Wife)

(Address) 3302 Ruckert Ave.

15 Filed ..... 19..... C. HAMPSON JONES, M. D.

Registrar

Per .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8, 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Illuminating Gas Asphixiation

Suicide

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) (duration) ....yrs. ....mos. ....ds.

(Signed) J. H. Gallen, M. D.

(Coroner)

5/8/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the state ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial	20 UNDERTAKER	ADDRESS
Baltimore Cemetery	May 10, 1929	Henry Sander & Sons Inc	BALTIMORE ST. & BROADWAY.

OF DEATH in plain terms, so that it may be properly classified. Use abbreviations of occupation if very important. See instructions on back of certificate.

9-1929

Spec.—2-29-28—L. F. S.—500 Bks.

E 45774

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-002 Cat West Heights Homeland Ave

CERTIFICATE OF DEATH

E 45774

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1812 W. Lanvale ST. 16-22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jacob J. Bromwell

(a) RESIDENCE NO. 1812 W. Lanvale ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lydia Bromwell

6 DATE OF BIRTH (month, day, and year): Dec 10. 1860

7 AGE: Years 68 Months 4 Days 24 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer): Insurance

(c) Name of employer: Star Life Ins Co

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Jacob Bromwell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Ellen Sandsbury

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Miss Ella Bromwell
(Address) 1812 W. Lanvale St

15 Filed: MY 9-1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 8, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 31, 1929, to May 8th, 1929, that I last saw him alive on May 8, 1929, and that death occurred, on the date stated above, at 1 10 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Hypertrophy.

CONTRIBUTORY (Secondary) Bronchitis (duration) yrs. 1 mos. ds. Hypertension

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? 1812 W Lanvale St

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical.

(Signed) [illegible] M. D.

5/9/29. (Address) 912 Park Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: May 11 1929

20 UNDERTAKER: Wm Cook — ADDRESS: 1217 N Paul St

Spec.—1-10-21—M&T—1500 Bks.

~~24377~~ 45775

HEALTH DEPARTMENT—CITY OF BALTIMORE E 45775

CERTIFICATE OF DEATH. X 44

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL (ST.) (WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Royston Powell

(a) RESIDENCE NO. 15 S. West St. ST., ... WARD ..... York Pa

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. 4 mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Jane

6 DATE OF BIRTH (month, day, and year) March 8, 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	51	2		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 066

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Georgia

PARENTS

10 NAME OF FATHER John Powell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Georgia

12 MAIDEN NAME OF MOTHER Francis Kennedy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. Car.

14 Informant (Address) Friends

15 Filed MAY 9-1929 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 1929

17 I HEREBY CERTIFY, That I attended deceased from April 8 1929 to May 8 1929, that I last saw him alive on May 8 1929, and that death occurred, on the date stated above, at 2:55 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of April 20, 1929

Was there an autopsy? Yes

What test confirmed diagnosis? —

(Signed) Benj Masser, M. D.

(Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Centerville Pa — DATE OF BURIAL May 9 1929

20 UNDERTAKER A B Marshall — ADDRESS 3539 Falls Rd.

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45776

E 45776

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 1039 N. Calvert St. (Ward) 11-15

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Raymond H Vanhest

(a) RESIDENCE NO. 1039 N. Calvert ST. WARD Wash DC.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of husband of Bessie DuVall Vanhest

6 DATE OF BIRTH (month, day, and year) Nov. 12, 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	46	5	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Vice Pres & Sec'y U.S.L. Electric Co.

(b) General nature of industry, business, or establishment in which employed (or employer) Mfg. Electric batteries

(c) Name of employer U.S.L. Electric Co.

9 BIRTHPLACE (city or town) (State or country) Grundy Co., Iowa.

PARENTS

10 NAME OF FATHER Garrett B. Vanhest

11 BIRTHPLACE OF FATHER (city or town) (State or country) Johnstown, N. Y.

12 MAIDEN NAME OF MOTHER Ona Davis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Iowa.

14 Informant Helen Kreitling (Address) 1010 E. Capitol St. Washington D.C.

15 Filed 9-1929 C. HARRISON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9 1929

17 I HEREBY CERTIFY, That I attended deceased from March 4, 1929, to May 9, 1929, that I last saw him alive on May 9, 1929 and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Chronic arterial Hypertension

Acute nephritis

(duration) 1-2 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death? Niagara Falls, N. Y.

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? B.P., urine, etc.

(Signed) L. H. Parker per [illegible] M. D.

, 19 (Address) 1035 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington D. C.

DATE OF BURIAL May 1929

20 UNDERTAKER Chas. H. Grauer & Son 11 W. Mt. Royal Ave

ADDRESS

TION is very important. See instructions on back of certificate.

Spec.—7-17-26—A Co.—200 Bks.

Kelleher

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45777

CERTIFICATE OF DEATH

129 E 45777

REGISTERED NO.

1-PLACE OF DEATH 4301 Roland Ave

City of BALTIMORE: (No. Kirkleigh Rd St. 27-49 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A. Kelleher.

(a) RESIDENCE NO. Kirkleigh Rd St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): June 24 1846

7 AGE: Years 82 Months 9 Days 14 IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None. 0.0

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town)

(State or country): Ireland

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Ireland

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Ireland

14 Informant: Kirkleigh Rd

(Address) 4301 Roland Ave

15 Filed 9-1929 C. HAMPSON JONES, M. D. Registrar

Per ACH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8-1929 19

17 I HEREBY CERTIFY, That I attended deceased from May 3 19 29 to May 8 19 29, that I last saw her alive on May 8 19 29, and that death occurred on the date stated above, at 2 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

Old Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Mitral Regurgitation

(duration) 1 yrs. mos. ds.

18 Where was disease contracted

If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Chas. E. Lauer, M. D.

May 8 19 29 (Address) 1 W. Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery Date of Burial May 10 1929

20 UNDERTAKER: Chas. F. Evans & Son ADDRESS 118 North Royal Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45778 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

118-002

E 45778

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1409 E. Clement ST. 24-26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Augusta Saul.

(a) RESIDENCE NO. 1409 E Clement ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? 50 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow.

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Frederick Saul.

6 DATE OF BIRTH (month, day, and year) Jan 13. 1859.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70	3	26 25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework. 27

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Frederick Saylman

11 BIRTHPLACE OF FATHER (city or town) Germany. (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Germany. (State or country)

14 Informant Emily Saul

(Address) 1440 Hanover St

15 Filed MAY 9 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May. 8-1929

17 I HEREBY CERTIFY, That I attended deceased from May. 4, 1929, to May. 8, 1929.

that I last saw h. W. alive on May. 7, 1929.

and that death occurred, on the date stated above, at 9.50 a. m.

The CAUSE OF DEATH* was as follows:

Strangulation of Intestines

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No. refused Date of

Was there an autopsy? No.

What test confirmed diagnosis? None

(Signed) Thos. A. Stearns, M. D.

5/8 1929 (Address) 2878 Hartford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill.

DATE OF BURIAL May 11 1929

20 UNDERTAKER Charles L. Stearns

ADDRESS 150 E Fort Ave

Cor.—10-10-29—A Co.—100 Bks.

E 45779

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 45779

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Agnes Hospital 7-4-35 St., Ward)

2-FULL NAME Katheryn C. Potts

(a) RESIDENCE NO. 1309 Hull St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John H. Potts

6 DATE OF BIRTH (month, day, and year) Nov. 6 1889

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	48	6	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Maryland

PARENTS

10 NAME OF FATHER Thos. Buckley

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Ireland.

12 MAIDEN NAME OF MOTHER .....

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country)

14 Informant .....
(Address) 1309 Hull St.

15 Filed ..... 19 .....
C. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:
Struck by Street-Car - Fractured Skull - (Accidental)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Chas. W. Brooke M. D.

5/9. 1929 (Address) 3601 3rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL May 10 1929

20 UNDERTAKER Margaret E. Flynn — ADDRESS 1427 Light St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

Died E 45780

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45780

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 22-30 WARD)

REGISTERED NO. 161

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Winkleman

(a) RESIDENCE No. 322 S Eutaw ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 5-3-29

7 AGE	Years	Months	Days	If LESS than 1 day: hrs. or min.
				1 hrs. or 37 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Stanley Winkleman

11 BIRTHPLACE OF FATHER (city or town) Balt (State or country) Md

12 MAIDEN NAME OF MOTHER Ethel May Kellum

13 BIRTHPLACE OF MOTHER (city or town) Balt (State or country) Md

14 Informant (Address)

15 Filed 5/6, 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/3 1929

17

I HEREBY CERTIFY, That I attended deceased from 5/3, 1929, to 5/3, 1929,

that I last saw h[illegible] alive on 5/3, 1929,

and that death occurred, on the date stated above, at 10:30 a m.

The CAUSE OF DEATH* was as follows:

1 Placenta Previa

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Premature Birth

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Louis A Klopp M. D.

(Address) Mun 1400 E.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Board

ADDRESS

C. HAMPSON JONES, M. D.

MAY 6 1929

TION is very important. See instructions on back of Certificate.

9-1929

Spec.—2-29-28—L. F. S.—500 Bks.

E 45781

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

118-002

E 45781

1—PLACE OF DEATH University Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. 12-50 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henrietta Armstrong
Colored Female Apt.

(a) RESIDENCE NO. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 82 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	widowed

6a If married, widowed, or divorced, HUSBAND of (or) WIFE of Victor L Armstrong

6 DATE OF BIRTH (month, day, and year) Dec 15 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	4	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Geo. Merryman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Elizabeth Austin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Victor C. Armstrong
(Address) Hackensack N.J.

15 9 - 1929 19 HARRISON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9 1929

17 I HEREBY CERTIFY, That I attended deceased from April 27, 1929, to May 9, 1929, that I last saw her alive on May 1, 1929, and that death occurred, on the date stated above, at 10.35 a. m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction due to omental band

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Anemia

(duration) yrs. mos. 3 ds. 4

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of 4/29/29

Was there an autopsy? Yes

What test confirmed diagnosis? clinical & operative

(Signed) J. A. Gulick M. D.

5/8, 1929 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cem

DATE OF BURIAL May 10th 1929

20 UNDERTAKER Henry H. Tenbrink Sons

ADDRESS McCulloh & Richard Sts.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45782

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

24-001

E 45782

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Bon Secour Hosp ST. 21-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John F. Dieter

(a) RESIDENCE NO. 610 Wyatt ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 2 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	7	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant John L. Cole
(Address) 37 W. Catherine St

15 5-8-1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7-1929

17 I HEREBY CERTIFY, That I attended deceased from May 3, 1929, to May 7, 1929, that I last saw him alive on May 7, 1929 and that death occurred, on the date stated above, at 8 30 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. Murray Young, M. D.

5/8, 1929 (Address) 729 Park. Blvd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Westernlee cemetery	May 9 1929
20 UNDERTAKER George J. Smith	ADDRESS Holliday

Spec.—1-10-21—M&T—1500 Blks.

E 45783 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 45783

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2845 Woodbrook Ave 43-59 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Pensch

(a) RESIDENCE NO. 2845 Woodbrook Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7/6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 29 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	47	2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Accountant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Charles W. Z. Pensch

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Magdalene Lieck

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Bernard Pensch
(Address) 170 S Lakeside Ave

15 C. HAMPSON JONES, M. D.
19 29 Registrar

9 - 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 6, 1929, to May 7, 1929.

that I last saw him alive on May 7, 1929.

and that death occurred, on the date stated above, at 5.45 P. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) 3 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) J Edw Talbott, M. D.

May 7, 1929 (Address) 1355 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	May 10 1929
20 UNDERTAKER	ADDRESS
George J Smith	Hollins

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45784

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

87

E 45784

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Baltimore City Hosp. ST., 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Williams

(a) RESIDENCE NO. 1521 McElderry ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 5 1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Sherman Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Hospital Records

(Address)

15 5-9-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/4/29

17 I HEREBY CERTIFY, That I attended deceased from 3/15, 1929, to 5/4, 1929, that I last saw h[illegible] alive on 5/4, 1929 and that death occurred, on the date stated above, at 9 45 A m.

The CAUSE OF DEATH* was as follows:

Purulent Pericarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pericardial adhesions with decompensation (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 3/22/29

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. M. Lumpkin, M. D.

5/4, 1929 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Lebanon Cemetery	May 9 1929

20 UNDERTAKER Robert N. Williams ADDRESS 1515 N. McElderry St

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 45785 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101 E 45785

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: No. 405 W. Saratoga St. ST. H-25 WARD)

2-FULL NAME Eva A. Greer

(a) RESIDENCE. No. 405 W. Saratoga St. ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 21 81

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	6	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) New York St
(State or country) Clinton Corners Dutchess Co

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) Dont Know
(State or country)

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) Dont Know
(State or country)

14 Informant Mrs P. Sorensen
(Address) 405 W. Saratoga St

15 Filed . 19

Registrar

MAY 9 - 1929 C. HAMPSON JONES, M. D.

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9th 1929

17 I HEREBY CERTIFY, That I attended deceased from May 2, 1929, to May 9, 1929, that I last saw h— alive on May 8, 1929, and that death occurred, on the date stated above, at 6:20 A.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Toxaemia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. K. Gorman M. D.

. 19 (Address) 117 W. Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hyde Park N. Y. Dutchess Co. N. Y.

DATE OF BURIAL May 12 1929

20 UNDERTAKER H. W. McRoberts

ADDRESS 2038 N Monroe

TION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 45786

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 45786

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1325 E. Biddle ST. 10-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William E. Amos

(a) RESIDENCE NO. 1325 E. Biddle ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary M. Amos

6 DATE OF BIRTH (month, day, and year): Oct 7 1853

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
75	7	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Wm E Amos

11 BIRTHPLACE OF FATHER (city or town) (State or country): Harford Co Md

12 MAIDEN NAME OF MOTHER: Ann Clapp

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Harford Co Md

14 Informant: Mrs. Mamie Kahl

(Address) 1325 E Biddle Street

15 FILED 9-1929, 19 Per C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 7th 1929

17 I HEREBY CERTIFY, That I attended deceased from 5-4, 1929, to 5-7, 1929, that I last saw him alive on 5-7, 1929, and that death occurred, on the date stated above, at 11:40 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Degeneration

CONTRIBUTORY (Secondary) Chronic Intestinal Nephritis (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown (duration) 1 yrs. mos. ds.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) Paul Nuzum, M. D.

5-9, 1929 (Address) 1500 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: 5 10 1929

20 UNDERTAKER: George C. Ruth — ADDRESS: 1735 Harford Ave

Spec.—1-12-23—M&T—500 Blks.

E 45787 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 E 45787

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1622 Lamont St., 9-18 WARD)

2-FULL NAME John Mc Tighe

(a) RESIDENCE No. 1622 Lamont St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret Mc Tighe

6 DATE OF BIRTH (month, day, and year): 1861

7 AGE: 67 (Years | Months | Days | If LESS than 1 day, hrs or min.)

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Labor

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: City

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: John Mc Tighe

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Martin Mc Tighe

(Address) 632 Lamont Ave

15 Filed 9-1929, 19 Per C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 7 1929

17 I HEREBY CERTIFY, That I attended deceased from Mar 28, 1929, to May 7, 1929, that I last saw h alive on May 7, 1929 and that death occurred, on the date stated above, at 11 P m

The CAUSE OF DEATH* was as follows:

Carcinoma of Lymphatic glands of Cheek

(duration) 2 mos 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Bernard Cross, M. D.

May 9, 1929 (Address) 1216 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: May 11 1929

20 UNDERTAKER: George J. Ruth — ADDRESS: 1735 Harford Ave

TION IS very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 45788

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 45788

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1353 N Carey ST. 15-23 WARD)

2-FULL NAME Rosa Henderson

(a) RESIDENCE NO. 1353 N Carey ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Colored 5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed or divorced HUSBAND of (or) WIFE of John W. Henderson

6 DATE OF BIRTH (month, day, and year) April 1860

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) West Virginia

PARENTS

10 NAME OF FATHER William Bell

11 BIRTHPLACE OF FATHER (city or town) (State or country) W Virginia

12 MAIDEN NAME OF MOTHER Julia Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W Virginia

14 Informant Mrs Blanche Mintzer

(Address) 1353 N Carey St

15 May 9 1929 C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 7th, 1928, to May 10th, 1929.

that I last saw her alive on May 2nd, 1929

and that death occurred, on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Pract Anemia (Cortin)

(duration) 4 5 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. Hampson Jones, M. D.

, 19 (Address) 857 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery DATE OF BURIAL May 9, 29

20 UNDERTAKER Blanche E. Wright ADDRESS 1364 N Carey

TION is very important. See instructions on back of certificates

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45789

CERTIFICATE OF DEATH

31 E 45789

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2034 E. 31st St. ST., 4-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Richard Y. Cadmus

(a) RESIDENCE NO. 2034 E. 31st St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Katherine Cadmus (nee Tyrrell)

6 DATE OF BIRTH (month, day, and year) Aug. 18, 1862

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
66	8	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Supervisor of Radio

(b) General nature of indostry, business, or establishment in which employed (or employer) U. S. Government

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Eugene Cadmus

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Y.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Y.

14 Informant Mrs. Katherine J. Cadmus

(Address) 2034 E. 31st St.

15 Filed ..., 19 ... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7, 1929.

17 I HEREBY CERTIFY, That I attended deceased from June, 1928, to May 7, 1929

that I last saw h[illegible] alive on May 7, 1929.

and that death occurred, on the date stated above, at 11 45 p. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonary, chronic

San Leandro

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? Clinical course & physical findings, Sputum Culture

(Signed) Frederick S. Eldredge, M. D.

, 19 (Address) 336 Richmond Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Arlington National Cem.	May 10/29
20 UNDERTAKER	ADDRESS
Harry A. Wiske	53 [illegible]

Spec.—2-29-28—L. F. S.—500 Bks.

E 45790

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

4-E Biddle

31 E 45790

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 520 S. Highland Ave ST. 7 WARD) 6-E

2—FULL NAME Emil Trinks

(a) RESIDENCE NO. 520 S Highland Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. 7 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Marie Trinks

6 DATE OF BIRTH (month, day, and year) May 18. 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Saloon Keeper

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Emil A Trinks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Erwin Trinks

(Address) 520 S Highland Ave

15 Filed 9-1929 C. HAMPSON JONES, M. D. Registrar.

By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8. 1929

17 I HEREBY CERTIFY, That I attended deceased from April 11. 1929, to May 8 1929, that I last saw him alive on May 7. 1929 and that death occurred, on the date stated above, at 8:15 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? One negative T. B. Sputum

(Signed) Franklin Kapelmeister M. D.

. 19 (Address) 4 E. Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oakland Cem

DATE OF BURIAL 5/11 1929

20 UNDERTAKER H. H. Cook

ADDRESS 1217 E Ford St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45791

CERTIFICATE OF DEATH

101-001 E 45791

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 204 W Franklin St., 11-25 Ward)

2-FULL NAME Oscar A Hauptmer

(a) RESIDENCE NO. 204 W. Franklin St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 Color or Race: White | 5 Single, Married, Widowed or Divorced: (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 21 1860

7 AGE: Years 68 | Months 11 | Days 17 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Manufacturer
(b) General nature of industry, business, or establishment in which employed (or employer) 045
(c) Name of employer

9 BIRTHPLACE (city or town) New York
(State or country)

PARENTS

10 NAME OF FATHER Chas Hauptmer

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Anne Rockel

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Annie Hauptmer
(Address) 204 W Franklin

15 Filed ..... 19 ..... Registrar

9-1929

C. HAMPSON JONES, M.D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to death (Inquest, autopsy or inquiry) on the day stated above.
The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 4 ds.

CONTRIBUTORY (Secondary) Paralysis

(duration) ..... yrs. 3 mos. ..... ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) May 9 19 29 (Address) Coroner A. Reginald Hoffman M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery New York — DATE OF BURIAL 5/10 1929

20 UNDERTAKER Wm Cook Co — ADDRESS 1217 St Paul

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

(Wicenty Zaleski)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45792 E 45792

CERTIFICATE OF DEATH

X 166

REGISTERED NO. 16-37

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Bon Secours Hospital St., Ward)

2-FULL NAME Wincenty Zaleski

(a) RESIDENCE NO. Martel on Colgate St., Md Ward

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. — mos. 9 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Stanislawa Zaleski

6 DATE OF BIRTH (month, day, and year) Jan 10-1889

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	40	3	9 29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Machine Moulder
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Poland
(State or country)

PARENTS

10 NAME OF FATHER Paul Zaleski

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland

12 MAIDEN NAME OF MOTHER Ann Roska

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland

14 Informant Stanislawa Zaleski
(Address) Martel on Colgate Md

15 Filed May 9, 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Swallowing Concentrated Lye With Suicidal intent while Insane

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Martel Md

Did an operation precede death? No Date of

Was there an autopsy? Yes Autopsy

What test confirmed diagnosis?

(Signed) James M Fenton, M. D.

May 9, 1929 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart of Mary	May 10 1929
20 UNDERTAKER	ADDRESS
John M Weber	431 E Chester

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 45793 HEALTH DEPARTMENT—CITY OF BALTIMORE E 45793

CERTIFICATE OF DEATH.

100-901

1-PLACE OF DEATH — Registered No. .....

City of BALTIMORE: (No. 2905 Dillon St., 1-1 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Michael Mostwinowski

(a) Residence No. 2905 Dillon St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word.) single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) March 21 1927

7-AGE, 2 yrs. 1 mos. 16 ds. If LESS than 1 day, ... hrs. or .... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... none

(b) General nature of Industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Balto.....
(State or Country),

PARENTS.

10-NAME OF FATHER, Michael Mostwinowski

11-BIRTHPLACE OF FATHER (city or town)... Poland....
(State or Country),

12-MAIDEN NAME OF MOTHER, Elenora Tyszka

13-BIRTHPLACE OF MOTHER (city or town).. Poland...
(State or Country),

14- (Informant)..Michael Mostwinowski..
(Address)..2905 Dillon St.....

15- Filed ..... 192 ..... Registrar.

HAMPSON JONES, M.D.

9-1929

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 7/29

17- I HEREBY CERTIFY, That I attended deceased from April 26, 1929 to May 7 1929 that I last saw h.. alive on May 7 1929 and that death occurred, on the date stated above, at 7.15 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

Primary

(Duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Acute myocarditis

(Duration) ..... yrs. ..... mos. 2 ds.

18-Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Observation

(Signed) Horace B. Tilton, M. D.

5/8, 1929 (Address) 314 S. Highland Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St. Stanislaus Cem. DATE OF BURIAL, May 10 1929

20-UNDERTAKER. Stephen J. Fialkowski Inc. ADDRESS 1005 S. Kenwood Ave

INSTRUCTIONS ON BACK OF CERTIFICATE.

Cor.—10-10-29—A Co.—100 Bks.

E 45794

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

#45794

E 45794

REGISTERED NO.

1-PLACE OF DEATH: City Hospitals

City of Baltimore: (No. ~~Raymond Hopkins~~ 5-8 St., ... (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Raymond Hopkins

(a) RESIDENCE NO. 1431 Arbutus St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	C	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	21			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 040
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Bath City

PARENTS

10 NAME OF FATHER James Hopkins

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Sindurilla Duckett

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Bath Md

14 Informant Emma Hunt
(Address) 1431 Arbutus St

15 [illegible] 19

Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 5 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:
Homicide Pistol
Gunshot of Abdomen
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Shock
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1713 Clinton
Did an operation precede death? yes Date of May 4
Was there an autopsy? yes
What test confirmed diagnosis? Autopsy
(Signed) H. Lee Steele, M. D.
19 (Address) 1402 Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cemetery — DATE OF BURIAL May 10 1924

20 UNDERTAKER Robert W. Allen — ADDRESS 1515 Druid Hill Ave

V 101929 C. HAMILTON JONES, M. D.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45795

CERTIFICATE OF DEATH

E 45795

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH Balto City Hospts

CITY OF BALTIMORE: (No. Balto Md ST., 14-21 WARD)

2—FULL NAME Eva Tabb

(a) RESIDENCE NO. 215 N. Bruce St. ST., WARD

(Usual place of abode) 215

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
38				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 070

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Tabb

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Della Cook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Balto City Hospt (Address) Balto Md

15 [illegible] HAMPSON JONES, M. D. Registrar

[illegible] 10 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-6-29

17 I HEREBY CERTIFY, That I attended deceased from 3-18-, 1929 to 5-6, 1929 that I last saw her alive on 5-6, 1929 and that death occurred, on the date stated above, at 7.05 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tbc + Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Psychosis w/ Cerebro Spinal Lues

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Clinical Laboratory

What test confirmed diagnosis?

(Signed) John Goodwin M. D.

5/7, 1929 (Address) Balto City Hospt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery — DATE OF BURIAL May 8, 1929

20 UNDERTAKER Mrs. Katie R. Williams — ADDRESS 322 N. Schroeder St.

Spec.—1-12-23—M&T—500 Blks.

Carson

HEALTH DEPARTMENT—CITY OF BALTIMORE

45796

CERTIFICATE OF DEATH.

11-00

E 45796

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 956 N. Howard St. H-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachel B. Carson

(a) RESIDENCE NO. 956 N. Howard ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew Carson

6 DATE OF BIRTH (month, day, and year) DEC 15 1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	31	4	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Isid L. Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Emma Morris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Andrew Carson

(Address) 956 N. Howard St

15 Filed MAY 10 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 1929.

17 I HEREBY CERTIFY, That I attended deceased from April 8, 1929 to May 8, 1929.

that I last saw her alive on May 8, 1929

and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Influenza

(duration) — yrs. 1 mos — ds.

CONTRIBUTORY (Secondary) Cardiac insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. H. Pelletreau, M. D.

, 19 (Address) 817 Hamilton Ter

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Ct — DATE OF BURIAL May 11 1929

20 UNDERTAKER C. L. Brown's Son — ADDRESS 1614 W. Pratt St

TION is very important. See instructions on back of certificates.

MAY 10 1929

Spec.—2-29-28—L. F. S.—500 Bks.

E 45797 HEALTH DEPARTMENT—CITY OF BALTIMORE 31 E 45797

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 15 N Castle ST., 6-9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank Kaptain

(a) RESIDENCE NO. 15 N castle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Elizabeth Kaptain

6 DATE OF BIRTH (month, day, and year) Feb 14-1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	49	2	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 0 to 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Antone Kaptain

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rose Lucas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Elizabeth Kaptain

(Address) 15 N Castle

MAY 9 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9, 1929

17 I HEREBY CERTIFY, That I attended deceased from 3-20, 1929, to 5-9, 1929

that I last saw h... alive on 5-9, 1929

and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward Lee ( ) M. D.

5/10 1929 (Address) 413 N Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	May 11 1929
20 UNDERTAKER	ADDRESS
M. F. E. Hoffman	3 E Lan

Spec.—2-29-28—L. F. S.—500 Bks.

E 45798 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 45798

1—PLACE OF DEATH

REGISTERED NO. 2145

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST., C. B. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Chancey Cromwell

(a) RESIDENCE NO. 1913 Kelly ave. Mt. Wash. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1911

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	18			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 0410

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Cromwell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Bertha Butler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed MAY 10 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 3, 1929, to May 7, 1929, that I last saw him alive on May 7, 1929 and that death occurred, on the date stated above, at 3.30 A. m.

The CAUSE OF DEATH* was as follows:

Caseous pneumonia

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical and autopsy

(Signed) Henry C. Smith M. D.

5-7-, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Calvary	5/10/ 1929
20 UNDERTAKER Frank I Beasley	ADDRESS 578 N Bond

Spec.—1-10-21—M&T—1500 Bks.

E 45799

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 45799

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1016 Hanover St. ST. 23-31 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Goemmer.

(a) RESIDENCE NO. 1016 Hanover St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 26 yrs. ds. How long in U. S., if of foreign birth? 36 yrs. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White.	Married.

5a If married, [redacted] (or) WIFE of Charles Goemmer.

6 DATE OF BIRTH (month, day, and year) June 18, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	10	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) Germany.

10 NAME OF FATHER George Lentz.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Margaret Rickriegel.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Charles Goemmer. (husband)

(Address) 1016 Hanover St.

15 Filed ....., 19 C. HAMPSON JONES, M. D. Registrar

AY 101529

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9th. 1929

17

I HEREBY CERTIFY, That I attended deceased from March 21, 1929, to March 9th. 1929, that I last saw h er alive on March 8th. 1929 and that death occurred, on the date stated above, at 1.50 a. m.

The CAUSE OF DEATH* was as follows:

Organic disease of the Heart and Kidneys.

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Acute dilatation of the Heart (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical diganosis.

(Signed) Otto M. Heinbandt, M. D.

5/9 1929 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem DATE OF BURIAL: May 11 1929

20 UNDERTAKER: E Schloman & Son ADDRESS: 1034 Hanover St

Spec.—1-10-21—M&T—1500 Bks.

E 45800

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45800

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Sinai Hospital

REGISTERED NO. 1929

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Monument & Rutland ST. 27-54 WARD)

2-FULL NAME Milton Smith.

(a) RESIDENCE No. 5616 Cross Country Blvd ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April, 19 1890

7 AGE — Years: 39 — Months: — — Days: 21 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer): 066

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto, Md.

PARENTS

10 NAME OF FATHER: Samuel Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Clara Klang

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Mrs. G. Rosenbush

(Address) 5616 Cross Country Blvd.

15 Filed 1929 By C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-10 1929

17 I HEREBY CERTIFY, That I attended deceased from 3-13, 1929, to 5-10, 1929,

that I last saw him alive on 5-10, 1929,

and that death occurred, on the date stated above, at 7.15 a m.

The CAUSE OF DEATH* was as follows:

Uremia Retinitis

Nephritis

Hypertension

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) B. Cohen, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship

DATE OF BURIAL: 5/14 1929

20 UNDERTAKER: D. Baird Sons & Co.

ADDRESS 115-20 W. Mt. Royal Ave

Y 101929

TION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45801

CERTIFICATE OF DEATH

E 45801

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 763 W. Franklin St. 17-76 Ward)

2-FULL NAME Benjamin James

(a) RESIDENCE NO. 763 W. Franklin St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	63			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) 015
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Md

PARENTS

10 NAME OF FATHER George James

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) England

12 MAIDEN NAME OF MOTHER Millision Jones

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) England

14 Informant Mr. Walter James
(Address) 1507 N Patterson Park Ave.

15 Filed ....., 19..... .....
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Fractured Skull
Fell down Stairs.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? at home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Eugene Ellert, M. D.

5/10. 1929. (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL May 11 1929

20 UNDERTAKER John Ulrich

ADDRESS 128 E Eutaw

MAY 10 1929 C. H. Huddleston, M. D.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

45802 1. PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3506 E Lombard (WARD) 6 37

REGISTERED NO. 31 E 45802

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Mitchell.

(a) RESIDENCE NO. 3506 E Lombard St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Magdaline Leonard

6 DATE OF BIRTH (month, day, and year) Sept 1 - 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	8	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Conductor

(b) General nature of industry, business, or establishment in which employed (or employer) Balt City Ry.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Thos Mitchell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Laura Simpson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Magdalene Mitchell

(Address) 3506 E Lombard

15 Filed ... 19 C. HAMPTON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 - 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1928, to May 8, 1929

that I last saw him alive on May 6 1929

and that death occurred, on the date stated above, at 10:20 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Epithelioma

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical and Physical

(Signed) Geo L. Watkins M.D.

May 10. 1929 (Address) 224 E. 39th

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem

DATE OF BURIAL May 11 1929

20 UNDERTAKER John Elliott

ADDRESS 2225 Ellerslie

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45803

CERTIFICATE OF DEATH

× 31 E 45803

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1900 Division ST. 14-20 WARD)

2—FULL NAME Annie White

(a) RESIDENCE NO. 1900 Division ST., WARD 20

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1903

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	26			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Robert Clayton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Charles Wells

(Address) Monroe Bass Va.

15 Filed MAY 10 1929 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 2, 1929, to May 7, 1929, that I last saw her alive on May 6, 1929 and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Contributory History 4 months (duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) T. K. Gorman, M. D.

5-8, 1929 (Address) 117 W. Saratoga St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Monumental Va

DATE OF BURIAL 5-10 1929

20 UNDERTAKER Daniel Easton

ADDRESS 716 E Balto

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE E 45804

E 45804

CERTIFICATE OF DEATH

REGISTERED NO. 24-04

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1313 Winchester ST. 16-23 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alexander Amby

(a) RESIDENCE NO. 1313 Wibchester ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Amby

6 DATE OF BIRTH (month, day, and year) July 9, 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 640

(c) Name of employer Odd Jobs

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Thomas Amby

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Lizzie Wayman

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

11 Informant Elizabeth Queen

(Address) 1143 Woodyear St.

15 Filed May 10 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9, 1929

17 I HEREBY CERTIFY, That I attended deceased from Mayl, 19 29, to May 9 19 29, that I last saw him alive on May 9 19 29 and that death occurred, on the date stated above, at 2: 30 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemmorhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical exam.

(Signed) Walter J. Jackson, M. D.

19 (Address) 1631 W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 5-10 1929

20 UNDERTAKER Daniel Easter

ADDRESS 916 Mass

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45805 E 45805

CERTIFICATE OF DEATH.

REGISTERED NO. 10-1472

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST. 10-14 WARD)

2-FULL NAME Henry L. Bowling

(a) RESIDENCE NO. Preston + Valley ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 6th 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	8	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER William Bowling

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Mary Barnum

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Little Sisters of the Poor (Address) Preston + Valley Sts

15 Filed MAY 10 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10th 1929

17

I HEREBY CERTIFY, That I attended deceased from May 10 1929 to May 10 1929

that I last saw him alive on May 5 1929,

and that death occurred, on the date stated above, at 4 2. m.

The CAUSE OF DEATH* was as follows:

Locomotor ataxia

Unknown (duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. A. Ahrens, M. D.

May 9/29 19 (Address) 1133 Valley St

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL May 10 1929

20 UNDERTAKER Rita Riedfeld — ADDRESS 914 Gruman Ave

MAY 10 1929

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45806

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 45806

1—PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO. 14579 129

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Boswell

(a) RESIDENCE NO. 560 Gold ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred ½ yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	24			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer) 0/0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Andrew Boswell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ruth White

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penna.

14 Informant Records of

(Address) Baltimore City Hospitals

15 Filed ..... 1929 C. HAMILTON JONES, M. D. Registrar

101529

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 29, 1929, to May 7, 1929, that I last saw him alive on May 7, 1929 and that death occurred, on the date stated above, at 1:00 P. m.

The CAUSE OF DEATH* was as follows:

Sickle-cell anemia

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic nephritis — Secondary anemia (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Laboratory — ctsk

(Signed) Marion M. McClain, M. D.

, 19 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Norfolk Va	May 11 1929
20 UNDERTAKER	ADDRESS
John D Stevens	1513 W. Lanvale St

of

Spec.—1-10-21—M&T—1500 Bks.

Henrietta P Chapman.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45807

CERTIFICATE OF DEATH.

86-001

E 45807

REGISTERED NO.

1-PLACE OF DEATH Bradley

CITY OF BALTIMORE: (No. 709 Bradley ST. 17-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henrietta Pratt Chapman

(a) RESIDENCE NO. 709 Bradley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Chas. Chapman

6 DATE OF BIRTH (month, day, and year): 9/7/1886

7 AGE: Years 47 Months 11 Days - If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): Dentist

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balt. Md

PARENTS

10 NAME OF FATHER: Chas. Pratt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Harriet Stelle

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Bessie Pratt

(Address): 709 Bradley

15 Filed 1929 CHARLTON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/9/1929

17 I HEREBY CERTIFY, That I attended deceased from 4/21, 1929, to 5/9, 1929.

that I last saw h alive on 5/9, 1929

and that death occurred, on the date stated above, at 4:15 P.M.

The CAUSE OF DEATH* was as follows: Fractured Femur

Abscess

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (secondary) Arteriosclerosis (duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? Washington, D.C.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Lee Cole, M. D.

(Address) 924 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery

DATE OF BURIAL: 5-11 1929

20 UNDERTAKER: Chas. G. Cooper

ADDRESS: 514 N. Calhoun St

CAUSE OF DEATH must be given. If unknown, so state. If not buried or cremated, state disposition. TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Barishansky. ✓

E 45808 HEALTH DEPARTMENT—CITY OF BALTIMORE E 45808

CERTIFICATE OF DEATH. X 124

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital ST., 1-13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Barishansky.

(a) RESIDENCE NO. 1116 5th St. N.W. Washington, D.C. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Raphael M. Barishansky

6 DATE OF BIRTH (month, day, and year): Unknown.

7 AGE: 57 (Years / Months / Days; If LESS than 1 day, hrs. or min.)

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: David Baer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): —

14 Informant (Address): Hosp. record

15 Filed 10 1929 C. HAMPSON JONES, M. D., Registrar

PMT

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 10 1929.

17 I HEREBY CERTIFY, That I attended deceased from 4/19 1929 to 5/10 1929.

that I last saw her alive on 5/10 1929,

and that death occurred, on the date stated above, at 5/10 m.

The CAUSE OF DEATH* was as follows:

Pulm. Disease.

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary): Cardiac failure.

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of 5/6/29.

Was there an autopsy? Yes.

What test confirmed diagnosis? Usual.

(Signed) J. E. Eardman, M. D.

19 (Address) Sinai Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Washington D.C. DATE OF BURIAL: May 10 1929

20 UNDERTAKER: B. Dawzansky ADDRESS: 3501-14 St. N. W. Wash. D.C.

CAUSE OF DEATH must be stated plainly, so that it may be properly coded. TION is very important. See instructions on back of certificates.

Spec.—2-25-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45809

CERTIFICATE OF DEATH

1—PLACE OF DEATH St Josephs Hospital

CITY OF BALTIMORE: (No. Eutaw & Oliver Sts. ST.) 8-45-90 (WARD)

REGISTERED NO. E 45809

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Murray

(a) RESIDENCE NO. 1678 Normal Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, ~~Married~~, Widowed, or Divorced (write the word)
Male.	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Ellen A Murray.

6 DATE OF BIRTH (month, day, and year) Oct 4/1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59.	7	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brick Layer

(b) General nature of industry, business, or establishment in which employed (or employer) City

(c) Name of employer City Balt. 011

9 BIRTHPLACE (city or town) (State or country) Freedom. R. I.

PARENTS

10 NAME OF FATHER John Murray.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Carde.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Catherine Guest.

(Address) 61 Wickham. Lenith

15 Filed 5-10-29 C. HAMPSON JONES, M. D. Registrar

101929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8, 1929

17

I HEREBY CERTIFY, That I attended deceased from March 31, 1929, to May 8, 1929

that I last saw him alive on May 8, 1929

and that death occurred, on the date stated above, at 10.20 P m.

The CAUSE OF DEATH* was as follows:

Auricular Fibrillation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) V. Mennes, M. D.

, 19 (Address) St Josephs Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery.

DATE OF BURIAL May. 11 1929

20 UNDERTAKER Geo. J. Rutt

ADDRESS 1735 Harford Ave

Spec.—1-10-21—M&T—1500 Blks.

E 45810 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 45810 REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2100 Mt Holly ST., 15-66 WARD

2-FULL NAME Mrs-Cassandra-C Grim-

(a) RESIDENCE NO. 2100 Mt-Holly- ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George O Grim

6 DATE OF BIRTH (month, day, and year) Dec 2 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	5	23	7

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Queens Anne Co (State or country) Md

PARENTS

10 NAME OF FATHER William Clayland

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Prudence Story

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant George F Grim (Address) 2100 F Mt Holly st

15 C. HAMPSON JONES, M. D. Registrar

MAY 10 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 5 1929 to May 9 1929, that I last saw her alive on May 9 1929, and that death occurred, on the date stated above, at 5-45 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Oedema Lungs

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) E. Gill Hall, M. D.

May 10 1929 (Address) 1631 E. North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	May 11 1929
20 UNDERTAKER George J Smith	ADDRESS 153 Hollins

CAUSE OF DEATH to plainly written, so that it may be properly TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

924 29 E 45811

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45811

CERTIFICATE OF DEATH.

44

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL (ST.) 6-11 (WARD)

2-FULL NAME William Ross

(a) RESIDENCE No. 150 N. Ellwood ST., 2nd WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ? Widower

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Henry Ross

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Rankin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Friend

(Address) JOHNS HOPKINS HOSPITAL

15 DATE RECEIVED 1929 C. HAMPSON JONES, M. D. Registrar

PHI BCH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1929

17 I HEREBY CERTIFY, That I attended deceased from April 15 1929 to May 10 1929 that I last saw him alive on May 10 1929 and that death occurred, on the date stated above, at 4 a.m. p.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach
metastases to Peritoneum.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Secondary Anemia

Cachexia (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of April 22 1929

Was there an autopsy? Refused

What test confirmed diagnosis?

(Signed) Ben Mussey M. D.

5-10 1929 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Darlington Md.

DATE OF BURIAL 5-10 1929

20 UNDERTAKER Herbert S. Bailey

ADDRESS Darlington Md.

TION is very important. See instructions on back of certificates.

10 1929

Spec.—2-29-28—L. F. S.—500 Bks.

E 45812

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49 E 45812

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1405 Mt. Royal Ave. ST. 14-20 WARD)

2—FULL NAME Katherine Forbes

(a) RESIDENCE NO. 1405 Mt. Royal Ave. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. - mos. - ds. How long in U. S., if foreign birth? - yrs. - mos. - ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) ------

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	About 82	--	--	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) St. Mary's County
(State or country) Maryland

PARENTS

10 NAME OF FATHER James John Forbes

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Eliza C. Thomas

13 BIRTHPLACE OF MOTHER (city or town) St. Mary's
(State or country) Maryland

14 Informant Mrs. Frances MacMaster

(Address) 1405 Mt. Royal Avenue

15 Filed 101929 C. HAMPSON JONES, M. D.
By RCH Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 30, 1925, to May 9, 1929, that I last saw h[illegible] alive on May 2, 1929 and that death occurred, on the date stated above, at 9 [illegible] a. m.

The CAUSE OF DEATH* was as follows:

Cancer (Cutlus carcinoma) Lingua
in left Hand. Radical Op. Lymphatics
metastasis. Recurrence

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Spontaneous pneumothorax (left)

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Dec 1925 Oct 1927

Was there an autopsy? No

What test confirmed diagnosis? Biopsy.

(Signed) Chas C Maydd, M. D.

5/9, 1929 (Address) 8 E. Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Deep Falls, St. Mary's Co. Md.	5/11 1929

20 UNDERTAKER Henry U. Mears & Son ADDRESS 805 N. Calvert

Spec.—2-29-28—L. F. S.—500 Bks.

E 45813

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001 E 45813

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 4925 Eastern Ave St., 16-37 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Clara Ward

(a) RESIDENCE NO. 4925 Eastern Ave St. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. 5 mos. 13 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Femal	W	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Walter Ward

6 DATE OF BIRTH (month, day, and year) Nov 25 1875

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
53	5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary E Hazard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Anna Arundel Co Md

14 Informant Mr Walter Ward

(Address) 4925 Eastern ave

15 Filed MAY 19 1929 C. HAMPSON JONES, M. D. Registrar

101929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8/1929

17 I HEREBY CERTIFY, That I attended deceased from April 26, 1929, to May 8, 1929, that I last saw her alive on May 7 1929 and that death occurred, on the date stated above, at 2 55 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) — yrs. — mos. 12 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. C. Pelletreau, M. D.

19 (Address) 817 Hamilton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cemetery	May 11 1929

20 UNDERTAKER John F Denny ADDRESS 715 Lig Ave

Spec.—2-29-28—L. F. S.—500 Bks.

E 45814

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 45814

REGISTERED NO.

1—PLACE OF DEATH Home

CITY OF BALTIMORE: (No. 1002 William ST. 24-23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Emma Virginia Espey

(a) RESIDENCE NO. 1002 William ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. 6 mos. 28 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward Espey

6 DATE OF BIRTH (month, day, and year) Oct 12 1874

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
54	6	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-work

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER John T. Gronewell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Emma J. Coyle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Hanna Estey

(Address) 1002 William St

15 Filed MAY 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10/29

17 I HEREBY CERTIFY, That I attended deceased from Mar 1, 1928, to May 10, 1929 that I last saw h alive on May 10, 1929 and that death occurred, on the date stated above, at 9:40 a in.

The CAUSE OF DEATH* was as follows:

Chron Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Apoplexy, Coronary Sclerosis Mar 2 to May 10 1929 (duration) yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) C Wallace Waller, M. D.

, 19 (Address) 910 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet Cemetery

DATE OF BURIAL May 13 1929

20 UNDERTAKER John F. Denny

ADDRESS 715 Light St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45815

CERTIFICATE OF DEATH

E 45815

1—PLACE OF DEATH Home

REGISTERED NO.

CITY OF BALTIMORE: (No. 116 E Montgomery ST. 7233 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Miss Helen Vannes Saunders

(a) RESIDENCE NO. 116 E Montgomery ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 4 1908

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20	7	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Newland, Richmond Co Virginia

PARENTS

10 NAME OF FATHER Otis M. Saunders

11 BIRTHPLACE OF FATHER (city or town) Newland (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mamie Nash

13 BIRTHPLACE OF MOTHER (city or town) Newland (State or country) Virginia

14 Informant Otis M. Saunders
(Address) Newland, Va.

15 Filed 10 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 1929

17 I HEREBY CERTIFY, That I attended deceased from May 6, 1929, to May 8, 1929.

that I last saw h-- alive on May 8, 1929

and that death occurred, on the date stated above, at 10 15 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

May 17 (duration) 6 mos. yrs. mos. 1929 ds.

CONTRIBUTORY (Secondary) T Tuberculosis (Larynx)

May 6 to (duration) 2 yrs. 2 mos. d

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) W. Williams Wilkins M. D.

, 19 (Address) 710 Light St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Newland, Richmond Co. Va. Via Auto

DATE OF BURIAL May 12 1929

20 UNDERTAKER John F. Denny

ADDRESS 715 Light St

Spec.—2-29-28—L. F. S.—500 Bks.

E 45816

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 45816

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2303 Harlem Ave. ST. 16-18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Catherine Elizabeth Buttner,

(a) RESIDENCE NO. 2303 Harlem Ave. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) December 27, 1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25	4	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER August Buttner,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Caroline Freitag,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant August Buttner
(Address) 2303 Harlem Ave

15 Filed 1 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1928 to May 9, 1929 that I last saw h[illegible] alive on May 9, 1929 and that death occurred, on the date stated above, at 11 30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
Myelocolitis

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis (duration) 4 yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Robert C Nitch, M. D.

5/ , 19 (Address) 257 Wilkens ay

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL 19

20 UNDERTAKER Geo W Little

ADDRESS

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45817

CERTIFICATE OF DEATH

90 E 45817

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 40 Balto Gen Hosp ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frederick Kurtz

(a) RESIDENCE NO. 352 W York ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 4-1856

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
73	3	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labour. Odd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Christian Kurtz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Christina Bink

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Records

(Address)

15 10-1-1929 C. HAMPSON JONES, M. D., Registrar

For CAB

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 4, 1929, to May 9, 1929, that I last saw him alive on May 4, 1929 and that death occurred, on the date stated above, at 3.55 p. m.

The CAUSE OF DEATH* was as follows:

Acute Dilation of Heart

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Chr. Bronchitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. Hetrolt Wiesecke, M. D.

5/14, 1929 (Address) 20 Balto Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemetery	May 13 1929

20 UNDERTAKER Wm E Miller & Son ADDRESS 2634 Eastern Ave

Spec.—2-29-28—L. F. S.—500 Bks.

E 45818

HEALTH DEPARTMENT—CITY OF BALTIMORE

38

E 45818

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 9-46

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Marion Kuper

(a) RESIDENCE NO. 608 Gutman ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
84	85			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Friends

(Address)

15 Filed ..... 19..... Registrar

C. HAMPSON JONES, M. D.

101929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-10-29

17 I HEREBY CERTIFY, That I attended deceased from 7-12, 19 28, to 5-10, 19 29

that I last saw h.. alive on 5-10, 19 29

and that death occurred, on the date stated above, at 9:35 A. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

Aneurysm of arch of aorta

(duration) 1½ yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Physical signs

(Signed) ..... M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Jones Creek Anna Rundell	May 12 29

UNDERTAKER	ADDRESS
Chas C. Miller & Son	2334 Jefferson St

Spec.—2-29-28—L. F. S.—500 Bks.

E 45819

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

91-002 E 45819

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 37 S. Potomac ST. 1-2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret B Wainwright

(a) RESIDENCE NO. 37 S. Potomac ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
(or) WIFE of the late Isaac Wainwright

6 DATE OF BIRTH (month, day, and year) Mar 3 - 1841

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
88	2	6 5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER John Green

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Dashiell

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Nettie Fitch
(Address) Catonsville

15 10 T 1929, 19 C. HAMPSON JONES, M. D.
Registrar
Per HRW

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 29

17 I HEREBY CERTIFY, That I attended deceased from May 27, 19.., to May 8, 19..,
that I last saw h.. alive on May 8, 19..
and that death occurred, on the date stated above, at ....m.
The CAUSE OF DEATH* was as follows:

Senility

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H K Mark Jones, M. D.

May 10 (Address) 2238 E. Dale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery — DATE OF BURIAL May 11 1929

20 UNDERTAKER Mrs C. Miller & Son — ADDRESS 533 E Jeffery

Spec.—2-29-28—L. F. S.—500 Blks.

E 45820

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45820

CERTIFICATE OF DEATH

117

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Saint Josephs Hospital ST., 6-40 WARD)

2—FULL NAME Raymond Schuster

(a) RESIDENCE NO. 3149 Keyndale Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred x yrs. 3 mos. 18 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of D. Hilda Schuster

6 DATE OF BIRTH (month, day, and year) Jan 29, 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	36	3	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cadet & Manager

(b) General nature of industry, business, or establishment in which employed (or employer) Balto Dairy Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Joseph Schuster

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Anna Kroen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant D. Hilda Schuster

(Address) 3149 Keyndale Ave

15 Filed 10 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/10/29

17 I HEREBY CERTIFY, That I attended deceased from 5/4, 1929, to 5/10, 1929, that I last saw h. im alive on 5/10, 1929 and that death occurred, on the date stated above, at 6:40a m.

The CAUSE OF DEATH* was as follows:

Appendicitis

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of 5/4/29

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. H. [illegible] M. D.

, 19 (Address) St Joseph Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Westernburn	May 13 1929

20 UNDERTAKER A Howard Evans ADDRESS 38 E Fayette

Spec.—1-10-21—M&T—1500 Bks.

E 45821

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 45821

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2709 Bellvoir Ave St. 18 WARD 14

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anne Worthington Love

(a) RESIDENCE NO. 2709 Bellvoir Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James A. Love

6 DATE OF BIRTH (month, day, and year) June 4, 1846

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or min.
	82	11	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — None

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick Md.

PARENTS

10 NAME OF FATHER Roger A. Worthington

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Shipley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Frederick Md.

14 Informant Mrs. Lynn Warne.

(Address) 2709 Bellvoir Ave

15 Filed 19 C. THAMPSON JONES M. D. (Registrar)

101929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9 1929

17

I HEREBY CERTIFY, That I attended deceased from May 3, 1929, to May 9, 1929, that I last saw h[illegible] alive on May 9 1929, and that death occurred, on the date stated above, at 9.20 P m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) H. L. Dooly M. D.

, 19 (Address) 1 Medical Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodland Cemetery Worthington family burying ground.

DATE OF BURIAL May 1 1929

20 UNDERTAKER Hugus & Jones Inc

ADDRESS 4th & Broadway

CAUSE OF DEATH in plain terms, so that it may be properly CODED. TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45822

CERTIFICATE OF DEATH

17 V E 45822

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital 18-26 Ward)

2-FULL NAME Edward Spratley

(a) RESIDENCE NO. 1071 W. Fayette St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henrietta Spratley

6 DATE OF BIRTH (month, day, and year) 1893

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	36			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Rigger
(b) General nature of industry, business, or establishment in which employed (or employer) Rigger
(c) Name of employer Bethlehem Steel Corp

9 BIRTHPLACE (city or town)
(State or country) Va

PARENTS

10 NAME OF FATHER Thomas Spratley

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Angela Robinson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Hospital Records
(Address)

15 Filed C. HAMPSON JONES, M. D., Registrar
per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Fractured Skull
Fractured Cervical Vertebrae
Suicide

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) T. B. Pleurisy & Effusion

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zeller, M. D.

5/10, 1929 (Address) 739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dist. National Cem

DATE OF BURIAL May 12th 1929

20 UNDERTAKER A. Jones

ADDRESS N. S. Gilmor

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Y 11 1929

Spec.—12 9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45823

CERTIFICATE OF DEATH.

124 **E 45823**

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1620 Madison ave (St.) 20 (Ward)

2-FULL NAME Richard Washington

(a) RESIDENCE NO. 1620 Madison ave St. ____ Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emilie Washington

6 DATE OF BIRTH (month, day, and year): Nov. 20 - 1898

7 AGE — Years: 31 — Months: 1 — Days: 17 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Porter

(b) General nature of industry, business, or establishment in which employed (or employer): 910

(c) Name of employer

9 BIRTHPLACE (city or town): Harrisburg Pa

(State or country)

PARENTS

10 NAME OF FATHER: Henry Washington

11 BIRTHPLACE OF FATHER (city or town): Pa.

(State or country)

12 MAIDEN NAME OF MOTHER: Emily Washington

13 BIRTHPLACE OF MOTHER (city or town): ____

(State or country)

14 Informant (Address): Irvette Washington 1620 Madison ave

15 MAY 11 1929 19 C. HAMPSON JONES, M. D., Registrar

Reg'd

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/7/ 19 29

17 I HEREBY CERTIFY, That I attended deceased from May 7 19 29 to May 7 19 29 that I last saw h__ alive on May 6 19 29 and that death occurred, on the date stated above, at 5:30 a m.

The CAUSE OF DEATH* was as follows:

Intestinal Hemorrhage (duration) ____ yrs. 2 mos. ____ ds.

CONTRIBUTORY (Secondary) Chronic Nephritis duration not known (duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? no Date of ____

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) John H. Lathrop, M. D.

5/9/29 (Address) 101 N. Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, State (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — Date of Burial 5/11/ 19 29

20 UNDERTAKER: Mrs. Geo. H. Holland — ADDRESS 1631 Druid Hill

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Dr Duker
928 E North Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45824

CERTIFICATE OF DEATH

90 E 45824

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) 1717 N. Bethel ST. 8-17 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry Schroder

(a) RESIDENCE NO. 1717 N. Bethel ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

3a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Bertha Schroder

6 DATE OF BIRTH (month, day, and year) Aug 31 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Brick Layer

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Miss Margaret Schroder

(Address) 1717 N. Bethel St

15 Filed 1 1 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9-1929

17 I HEREBY CERTIFY, That I attended deceased from MAY 8 - 1929, 19..... to MAY 9 - 1929, 19.....

that I last saw h... alive on MAY 9 - 1929, 19.....

and that death occurred, on the date stated above, at 11 30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation and thrombus of heart

(duration) ½ yrs. X mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) 5 yrs. X mos. X ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Gross clinical test

(Signed) Peter Duker M. D.

MAY 10 1929 (Address) 928 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Pauls Cemetery

DATE OF BURIAL May 13 1929

20 UNDERTAKER William Cook

ADDRESS 1217 E. Pratt St

Spec.—12-9-25—A Co.—200 Bks.

E 45825

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161 - E 45825

REGISTERED NO._____

1-PLACE OF DEATH Church Home & Infirmary

City of BALTIMORE: (No. 126 N. Broadway St 629 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Parker

(a) RESIDENCE NO. Havre De Grace Maryland Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 10, 1929

7 AGE	Years	Months	Days	IF LESS than 1 day 5 hrs. or 4 min.
	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Charles H. Parker

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Dorothy Kriete

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Aberdeen Md

14 Informant Mr. Charles H. Parker

(Address) Havre de Grace, Md.

15 Filed MAY 11 1929 C. HAMPSON JONES, M. D. Registrar

Per AKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 1929

17

I HEREBY CERTIFY, That I attended deceased from May 10, 1929, to May 11, 1929, that I last saw h... alive on May 11, 1929, and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Birth Injury
Fracture of Frontal Bone
Which was raised.

(duration) 0 yrs. mos. ds.

CONTRIBUTORY Cerebral Compression

(Secondary)

due to Haemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of May 10/29

Was there an autopsy? No

What test confirmed diagnosis? Physical Findings & Operation

(Signed) D. B Kelly, M. D.

, 19 (Address) Church Home & Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Havre de Grace Md Date of Burial May 11 1929

20 UNDERTAKER Geo F. Pennington ADDRESS Havre de Grace Md.

IMPORTANT. See instructions on back of certificates. Exact statement of OCCUPATION is very important. In plain terms, so that it may be properly classified. OF DEATH

Spec.–7-17-26—A Co.—200 Bks.

E 45826

Rosenblatt 167-08

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45826

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Mercy Hospital St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Rosenblatt

(a) RESIDENCE NO. 1150 W 34th Royal St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 9, 1929.

7 AGE Years Months Days 1 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md

PARENTS

10 NAME OF FATHER Eugene Rosenblatt

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Sara Blane

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Dist. C.

14 Informant Eugene Rosenblatt

(Address) 1150 W. 34th St. Royal Ave

Filed 5-11-1929

C. HAMPSON JONES, M. D. Registrar

By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/10/29 19

17 I HEREBY CERTIFY, That I attended deceased from 5/9/29, 19..., to 5/10/29, 19...,

that I last saw h.. alive on 5/10/29, 19...,

and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Atelectasis

(duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Premature Baby

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) ....., M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Ohel Shalom Cem	5/12/ 1929
20 UNDERTAKER	ADDRESS
Hurd Sondheim	[illegible]

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

MAY 11 1929

Spec.—2-29-28—L. F. S.—500 Bks.

In Combs Nanny St

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45827

CERTIFICATE OF DEATH

E 45827

90 Death

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 645 W. Lombard ST. 4-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Garnetiga L. Walter

(a) RESIDENCE NO. 645 W. Lombard ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Baltimore yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 2. 1912

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
16	7	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Girl

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cumberland Md

PARENTS

10 NAME OF FATHER Vincent Walter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Herrington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Vincent Walter

(Address) 645 W. Lombard St

15 5/11 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9, 1929

17 I HEREBY CERTIFY, That I attended deceased from Mar 1, 1929 to May 9, 1929

that I last saw her alive on May 9, 1929

and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. 2 mos. 9 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. L. Campbell M. D.

5/11, 1929 (Address) 1644 Hanover

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Wm. Cathedral

DATE OF BURIAL: May 13 1929

20 UNDERTAKER: Wm. Cathedral

ADDRESS: Troy-B-29

Spec.—2-29-28—L. F. S.—500 Bks.

E 45828

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

E 45828

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 70-69

CITY OF BALTIMORE: (No. 305 S Bethesda ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John G Harbaugh

(a) RESIDENCE NO. 305 S Bethesda ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	M

6 DATE OF BIRTH (month, day, and year) June 69

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Harness Maker

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Wright Harbaugh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Susan Gore

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mary Ellen Harbaugh

(Address) 305 S Bethesda

15 Filed ..... 19 .....

C. HAMPSON JONES, M.D.
Registrar

1 11929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9/29

17 I HEREBY CERTIFY, That I attended deceased from May 7, 1929 to May 9, 1929

that I last saw him alive on May 8, 1929

and that death occurred, on the date stated above, at 12-30 A.m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Rustan Dell, M. D.

5/11, 1929 (Address) 1509 W Lombard St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Emmitsburg Md.	May 13 1929
20 UNDERTAKER	ADDRESS
W M Routson	223 E Fayette

Cor.—12-9-25—A Co.—200 Bks.

Maggie Lacer

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45829

CERTIFICATE OF DEATH.

167-001

E 45829

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 400 N. Broadway St. 6-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Maggie Lacer

(a) RESIDENCE NO. 400 N. Broadway St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Lacer

6 DATE OF BIRTH (month, day, and year) About 1873

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	About 56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER George Presser

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine (Unknown)

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs. Bertha V. Assman

(Address) 1087 W. Fayette St.

15 Filed 19 CLARENCE JONES, M. D. Registrar

111929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ill. Gas Asphixiation -Suicide

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) (duration) ....yrs. ....mos. ....ds.

(Signed) J. S. H. Cook M. D.

(Coroner)

5/10/29 (Address) 508 E. North Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetary Date of Burial May 13 1929

20 UNDERTAKER Robt. J. Cook ADDRESS 1003 West Baltimore St

OF DEATH in plain terms, so that it may be properly classified. Last statement of OCCUPATIONS is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 45830 HEALTH DEPARTMENT—CITY OF BALTIMORE E 45830

CERTIFICATE OF DEATH. 91-002

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 321 S. Bouldin St. 10-2 WARD)

2-FULL NAME Julius Toskes

(a) RESIDENCE No. 321 S Bouldin ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? 40 yrs. ... mos. ... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lucia Toskes

6 DATE OF BIRTH (month, day, and year) Nov 1st 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
68 69		6	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Paul Toskes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Rose Vendetta
(Address) 406 Park Heights Ave

15 Filed MAY 11 1929 C. HAMPSON JONES, M. D.
Per RRP Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 21, 1929, to May 9, 1929, that I last saw h[illegible] alive on May 9, 1929, and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

heart failure

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary) arteriosclerosis

(duration) 5 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? no Date of ...

Was there an autopsy? ...

What test confirmed diagnosis? ...

(Signed) Charles Seeta, M. D.

, 19 (Address) 756 W. Fayette st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart — DATE OF BURIAL May 13 1929

20 UNDERTAKER Frank V. Ciketone — ADDRESS 2018 E. Baltimore st

CAUSE OF DEATH in plain terms, so that it may be properly TION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45831

CERTIFICATE OF DEATH

60-001

E 45831

1-PLACE OF DEATH Mercy Hospital

REGISTERED NO.

City of BALTIMORE: (No. 2-4 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Agnes Kurz

(a) RESIDENCE NO. 1928 E. Lombard St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct 26 1907

7 AGE: Years 21 Months 8 Days 14 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stenographer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto

(State or country)

PARENTS

10 NAME OF FATHER Frank H. Kurz

11 BIRTHPLACE OF FATHER (City or town): Balto

(State or country)

12 MAIDEN NAME OF MOTHER Catherine A. Wambach

13 BIRTHPLACE OF MOTHER (city or town): Balto

(State or country)

14 Informant: Catherine Kurz

(Address) 1928 E. Lombard St

15 Filed C. HAMPSON JONES, M. D. Registrar

Per

111929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: May 10, 1929

17 I HEREBY CERTIFY, That I attended deceased from 4/22/29, 19, to 5/10/29, 19, that I last saw her alive on 5/10/29, 19, and that death occurred, on the date stated above, at 11 57 A. m.

The CAUSE OF DEATH* was as follows:

Hyperthyroidism - Exophthalmic Goitre

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 5/7/29

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H. W. Fuller, M. D.

19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Date of Burial: May 13 1929

20 UNDERTAKER: M. F. E. Heppe & Son ADDRESS 3 E. Lanvale

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45832

CERTIFICATE OF DEATH

90 E 45832

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 28 or Halcyon Ave ST. 7 WARD 4 1)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Martha B Rose

(a) RESIDENCE NO. 28 or Halcyon Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? Life mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ferdinand C Rose

6 DATE OF BIRTH (month, day, and year) Oct 7 1857

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	71	7	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto, Md

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto, Md

14 Informant Mrs John Eichman

(Address)

15 Filed 1 11 1929 C. HAMPSON JONES, M. D. Registrar By RKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb 10, 1929, to May 11, 1929, that I last saw her alive on May 10, 1929 and that death occurred, on the date stated above, at 6:00 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Observation

(Signed) Horace B Sutton, M. D.

5/11, 1929 (Address) 315 So Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem

DATE OF BURIAL 5/14 1929

20 UNDERTAKER L Heemann

ADDRESS 32 S B'way

Spec.—2-29-28—L. F. S.—500 Bks.

E 45833

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 45833

1—PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 639 N. Calhoun ST. 16-26 WARD)

2—FULL NAME Roxie Felton

(a) RESIDENCE NO. 639 N. Calhoun ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Luther Felton

6 DATE OF BIRTH (month, day, and year) Aug. 28/07

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
21	9	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Norfolk Co.
(State or country) Va.

PARENTS

10 NAME OF FATHER Grant Sparrow

11 BIRTHPLACE OF FATHER (city or town) Norfolk Co.
(State or country) Va.

12 MAIDEN NAME OF MOTHER Emma Bracey

13 BIRTHPLACE OF MOTHER (city or town) Norfolk Co.
(State or country) Va.

14 Informant Octavia [redacted] Hinton

(Address) 639 N. Calhoun St.

15 Filed 11 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 6 1929 to May 9 1929 that I last saw her alive on May 9, 1929 and that death occurred, on the date stated above, at 9 p. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia
probably tubercular.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical exam.

(Signed) Walter J. Jackson, M. D.

, 19 (Address) 1631 W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Norfolk Va DATE OF BURIAL April 12 1929

20 UNDERTAKER Joseph A. Lively ADDRESS 709 N Monroe St.

Spec.—1-12-23—M&T—500 Blks.

E 45834

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45834

CERTIFICATE OF DEATH.

117

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital ST., 4-18 WARD)

2-FULL NAME Marvin Hepburn

(a) RESIDENCE No. 1325 Homewood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Sept 26, 1921

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
7	7	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Elmer Hepburn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co. Md

12 MAIDEN NAME OF MOTHER Ethel Athyns

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Elmer Hepburn

(Address) 1325 Homewood ave

15 Filed 1929, 19 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-10 1929

17 I HEREBY CERTIFY, That I attended deceased from 3-7, 1929 to 5-10, 1929.

that I last saw him alive on 5-10, 1929.

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Ruptured Appendix

Diffuse Peritonitis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Pneumonia & Lung abscess (Left) (duration) yrs. mos 14 ds.

18 Where was disease contracted if not at place of death? Lung (Bronchoscopic) Cases

Did an operation precede death? Yes Date of 5-10-29

Was there an autopsy? No

What test confirmed diagnosis? X ray & Phys Ex

(Signed) [illegible], M. D.

, 19 (Address) St Agnes Hosp Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Pk. Cemetery	May 13, 1929
20 UNDERTAKER	ADDRESS
Elmer W. Conklin	924 E Eager St

TION is very important. See instructions on back of certificate.

11929

Spec.—1-12-23—M&T—500 Blks.

E 45835 HEALTH DEPARTMENT—CITY OF BALTIMORE E 45835

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1842 Hayford av ST., 9-18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary. M. Ochs

(a) RESIDENCE NO. 1842. Hayford av ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed~~, ~~or Divorced~~, (write the word)
F.	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Ochs.

6 DATE OF BIRTH (month, day, and year) Feb 3 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	63	3	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Homemaker

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER William Peters.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant John Ochs.

(Address) 1842 Hayford av

15 Filed MAY 11 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 9, 1929, to May 9, 1929, that I last saw her alive on May 9, 1929, and that death occurred, on the date stated above, at 11.00 P. m

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Acute Pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Samuel B Wolfe, M. D.

May 10 1929 (Address) 1331 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemty — DATE OF BURIAL May. 13 1929

20 UNDERTAKER George. L. Ruth — ADDRESS 1735 Hayford av

TION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45836 — 100-001 — E 45836

CERTIFICATE OF DEATH

1—PLACE OF DEATH Balto City Hospt — REGISTERED NO. 3-4

CITY OF BALTIMORE: (No. Balto Md ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jacob Zablocki

(a) RESIDENCE NO. 1631 Fough St ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
76				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Balto City Hospt
(Address) Balto Md

15 Filed ....., 19.... HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-10-29

17 I HEREBY CERTIFY, That I attended deceased from 1-17, 1929 to 5-10, 1929

that I last saw h.. alive on 5-9, 1929

and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Terminal Broncho Pneumonia
Cardiac failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Changes Contributory

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Harry F. Dorman, M. D.

5/10, 1929 (Address) Balto City Hospt.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Stanislaus — DATE OF BURIAL: May 13 1929

20 UNDERTAKER: K. W. Ozazewski — ADDRESS: 1999 Eastern Ave

Spec—12-23-21—E.B.R.S.—400 Blks.

E 45837 HEALTH DEPARTMENT—CITY OF BALTIMORE E 45837

CERTIFICATE OF DEATH.

25-15 59-002

1-PLACE OF DEATH

City of BALTIMORE: (No. 1121 Monroe Circle St. 25 Ward 15) Registered No.

2-FULL NAME James Jefferson Jackson

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 1121 Monroe Circle St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Dec 31-1928

7-AGE. yrs. 4 mos. 10 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore Md (State or Country)

PARENTS.

10-NAME OF FATHER. Oregon Jackson

11-BIRTHPLACE OF FATHER (city or town) Maryland (State or Country)

12-MAIDEN NAME OF MOTHER. Dora Hager

13-BIRTHPLACE OF MOTHER (city or town) Md (State or Country)

14- (Informant) Oregon Jackson

(Address) 1121 Monroe Circle

15- Filed MAY 11 1929 C. HAMPSON JONES, M. D., Registrar. By

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 10-1929

17- I HEREBY CERTIFY, That I attended deceased from Feb 10 1929 to May 9 1929 that I last saw him alive on May 9 1929 and that death occurred, on the date stated above, at 7.30 A m.

The CAUSE OF DEATH* was as follows:

Congenital Heart disease

Marasmus & Malnutrition

Since Birth

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Ben D. Wooden M. D.

May 10 1929 (Address) 4 Joe Penniston

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Friendship Cemetery DATE OF BURIAL. May 11 1929

20-UNDERTAKER. Chenoweth & Son ADDRESS 3615 Eastern Ave

instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 45838

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45838

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 144. East St. (ST.) 54 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Kelley

(a) RESIDENCE NO. 144. East St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown 1889

7 AGE: Years 40; Months —; Days —; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Work

(b) General nature of industry, business, or establishment in which employed (or employer): 0/0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Richmond. Co, Va

PARENTS

10 NAME OF FATHER: Richard Kelly

11 BIRTHPLACE OF FATHER (city or town) (State or country): Richmond Co, Va

12 MAIDEN NAME OF MOTHER: Hennie Dixon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): New Port News

14 Informant (Address): John Kelley 415 Register St

15 Filed 19 Registrar: C. HAMPSON JONES, M. D.

1 11 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 8 1929

17

I HEREBY CERTIFY, That I attended deceased from May 6 1929. to May 8 1929.

that I last saw her alive on May 6 1929.

and that death occurred, on the date stated above, at 3.p m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(duration) Don't Know yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Anasarca

(duration) — yrs. — mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. F. Corder M. D.

19 (Address) 1904 Lafayette Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury cemetery

DATE OF BURIAL: May. 11. 1929

20 UNDERTAKER: Milton Davis

ADDRESS: 413 N Eden St

CAUSE OF DEATH to plain terms, so that it may be properly TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 45839

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

179 E 45839

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Balto City, Nos St. 5-8 Ward)

2-FULL NAME James H Powell

(a) RESIDENCE NO. 108 N Eden St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bessie Powell

6 DATE OF BIRTH (month, day, and year) Dec 25 1873

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	55	4	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Balto Tube Co

9 BIRTHPLACE (city or town)
(State or country) Howard Co

PARENTS

10 NAME OF FATHER John Powell

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) unknown

14 Informant Bessie Powell
(Address) 108 N Eden St

15 Filed ..... 19 C. HAMPSON JONES Registrar
per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 8 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris & Chronic Arthritis

Contributory Bronchial Pneumonia

Not after accident (duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? yes

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) James H Powers M. D.

May 11 1929 (Address) 708 Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodberry Cemetery — DATE OF BURIAL May 12 1929

20 UNDERTAKER Edward Bryan — ADDRESS 1631 Orleans St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45840

CERTIFICATE OF DEATH

E 45840

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1424 E. Fayette St., 14-27 Ward)

2-FULL NAME Lottie Gray Michel

(a) RESIDENCE NO. 1424 E. Fayette St., Ward
(Usual place of abode)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	black	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 10/1888

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	40	5	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Assorter
(b) General nature of industry, business, or establishment in which employed (or employer) Woolen Rag Shop
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Del.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) "
(State or country)

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) "

14 Informant Julia Gray
(Address) 1424 E. Fayette St

15 Filed 5/11 19 29 C. HAMPSON JONES, M. D., Registrar
Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) I find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible], M. D.

5/11/29 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: asbury cemetery — DATE OF BURIAL: may 12 1929

20 UNDERTAKER Edward Bryan — ADDRESS 1631 orleans st

Spec.—1-10-21—M&T—1500 Bks.

E 45841 HEALTH DEPARTMENT—CITY OF BALTIMORE E 45841

CERTIFICATE OF DEATH.

100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Delma May Scott

(a) RESIDENCE NO. 823 N. Bond ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE C.

5 Single, Married, Widowed, or Divorced. (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 5 1928

7 AGE Years Months 7 Days 5-4 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Ludd Scott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Donetta Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9 1929

17 I HEREBY CERTIFY, That I attended deceased from May 8 .1929. to May 9 .1929, that I last saw her alive on May 9 .1929, and that death occurred, on the date stated above, at 1030 P m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

CONTRIBUTORY (Secondary) Rickets (duration) yrs. mos 2 ds.

18 Where was disease contracted if not at place of death? (duration) yrs. 5 mos. ds.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) J. C. Godwin

5/10 .1929 (Address) Johns Hopkins Hosp. M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary DATE OF BURIAL May 11 1929

20 UNDERTAKER Mrs. R. A. Elliott ADDRESS 1325 Ashland Ave

CAUSE OF DEATH in plain terms. See instructions on back of certificates. TION is very important.

111929

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45842

CERTIFICATE OF DEATH

49

E 45842

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1108 N. Washington ST., 7-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Caroline Killmayer

(a) RESIDENCE NO. 1108 N. Washington ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., if foreign birth? 60 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

a If married, widowed, or divorced
(Husband) of Late
(or) WIFE of Conrad Killmayer

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About	82	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Joseph Bucher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs Grace Krupple

(Address) 1108 N. Washington St

15 Filed ..... 19 ..... Registrar

C. HAMPSON GANS, M. D.

11929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1929

17 I HEREBY CERTIFY, That I attended deceased from 3/22/29, 19..., to May 10, 1929, that I last saw him alive on May 9 10 a.m. 29 and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Neck

1 (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Metastasis

6 (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W. S. Gray 25, M. D.

5/11/29 19 (Address) 6 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	May 13 1929
20 UNDERTAKER	ADDRESS
Henry Hoeck Sons, Inc.	1201 E. Eager St

Spec.—2-29-28—L. F. S.—500 Bks.

E 45843

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 45843

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1008 N. Eden ST., 10th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Arthur A. Fladung

(a) RESIDENCE NO. 1008 N. Eden ST. 10 WARD
(Usual place of abode)

Length of residence in city or town where death occurred 31 yrs. 6 mos. 25 ds. How long in U. S., if foreign b'r'th? 24 yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): October 15 1897

7 AGE — Years: 31 | Months: 6 | Days: 25 | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Frederick Fladung

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Matilda Mardaga

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md

14 Informant: Mrs. Matilda Fladung

(Address): 1008 N. Eden St

15 Filed: 11 1929, 19

C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE

16 DATE OF DEATH (month, day, and year): May 10 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 4, 1928, to May 5, 1929, that I last saw him alive on May 5, 1929 and that death occurred, on the date stated above, at 10.15 P. m.

The CAUSE OF DEATH* was as follows:

Chr myocarditis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary): Acute dilatation of heart

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. G. Hornstein, M. D.

5/11, 1929 (Address) 733 Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: May 14 1929

20 UNDERTAKER: Henry Hoeck Sons Inc. — ADDRESS: 1301 E Eager St

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45844

CERTIFICATE OF DEATH.

E 45844

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hosp. ST., 7-13 WARD)

2-FULL NAME Samuel Feddeman

(a) RESIDENCE NO. Centerville Md. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Julia G. Feddeman

6 DATE OF BIRTH (month, day, and year): June 2, 1874

7 AGE — Years: 54 — Months: 11 — Days: 9 — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Griffith Turner Co

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Samuel R. Feddeman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant (Address): Wm A. Morrison 3900 Eastern Ave

15 Filed MAY 1 2 1929 C. HARRISON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/11 1929

17 I HEREBY CERTIFY, That I attended deceased from 5/9, 1929, to 5/11, 1929, that I last saw h/ alive on 5/11, 1929, and that death occurred, on the date stated above, at 11:30 A m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Hypertension & arteriosclerosis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Physical Exam.

(Signed) J. A. Gibson, M. D.

, 19 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Centerville Maryland — DATE OF BURIAL: 5/12 1929

20 UNDERTAKER: Wm Cook — ADDRESS 1217 Park

CAUSE OF DEATH in plain terms, so that it may be properly TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45845

CERTIFICATE OF DEATH

E 45845

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) S S Steed St. 25-27 (Ward)

2-FULL NAME William Mullin

(a) RESIDENCE NO. S S Steed St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. / ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (Write the word)
M	W.	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
About	34			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Oiler
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Capt Bay
(Address) S S Steed

15 Filed ..... 19 ..... C. HERBERT JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy
(Inquest, autopsy or inquiry.)

Thereon and from the evidence obtained by said Autopsy I find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Homicide

Gun Shot of Abdomen

(duration) ..... yrs. ..... mos. 2 hs

CONTRIBUTORY (Secondary) Shot

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? Yes Date of —

Was an autopsy [redacted] Yes

[redacted] that confirmed [redacted] Autopsy

5/10/29 (Signed) [redacted] Yates

(Address) 113 W Saratoga M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. John's New Cemetery Catonsville

DATE OF BURIAL 5/10/ 1929

20 UNDERTAKER J. G. Moran

ADDRESS 340 E Baltimore

MAY 12 1929

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

25-141
B 45846

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-281
E 45846

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. [illegible] WARD

2-FULL NAME Mary Regina Clemonetta

(a) RESIDENCE No. 3103 Westfield ST., Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1/24/27

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	3	13	16

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md —

PARENTS

10 NAME OF FATHER Lloyd Clemonetta

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co. Md

12 MAIDEN NAME OF MOTHER Rose Whitney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Friends —

(Address) JOHNS HOPKINS HOSPITAL

15 [illegible] C. HAMPSON JONES, M. D.

Registrar

MAY 12 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1929

17 I HEREBY CERTIFY, That I attended deceased from May 8 1929 to May 10 1929 that I last saw her alive on May 10 1929 and that death occurred, on the date stated above, at 8 45 P. m.

The CAUSE OF DEATH* was as follows:

nephrosis
(tubular nephritis)

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of 0

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) T. C. Goodwin, M. D.

5/11 1929 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Cathedral	May 13 1929

20 UNDERTAKER

ADDRESS

CAUSE OF DEATH to be plain terms, so that it may be properly TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45847

CERTIFICATE OF DEATH

91-002

E 45847

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Home for aged ST. 27-32 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rebecca Kaplan

(a) RESIDENCE NO. Belvedere & Greenspring Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? 40 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	widow

3a If married, widowed or divorced HUSBAND of (or) WIFE of Jacob Kaplan

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	90	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work old age

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Simon E. Sokoloff

(Address) Court House

15 Filed MAY 12 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/11/29

17 I HEREBY CERTIFY, That I attended deceased from July, 1928 to May 11, 1929 that I last saw h alive on , 19 and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

General arterio-Sclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Herman Seidel M. D.

, 19 (Address) 2404 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale

DATE OF BURIAL 5/12 1929

20 UNDERTAKER Jack Lewis

ADDRESS 1439 Eutaw

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45848

CERTIFICATE OF DEATH

E 45848

REGISTERED NO. 161-092

1-PLACE OF DEATH Mercy Hospital

City of BALTIMORE: (No. Calhoun & Saratoga Sts. 17-50 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Warner

(a) RESIDENCE NO. 3040 Barclay St. St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 11/1929

7 AGE Years / Months / Days: 2 minutes.

IF LESS than 1 day ... hrs. or 2 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Wallace Warner.

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Jessie Hood.

13 BIRTHPLACE OF MOTHER (City or town)

(State or country) Lutherville Md.

14 Informant Father - Wallace Warner

(Address) 3040 Barclay St

15 Filed ..... 19 ..... THOMAS JONES, M. D. Registrar

MAY 12 1929 Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 19 29

17 I HEREBY CERTIFY, That I attended deceased from May 11, 1929, to May 11, 1929, that I last saw her alive on May 11, 1929, and that death occurred, on the date stated above, at 3.17 P. m.

The CAUSE OF DEATH* was as follows:

Asphyxia -

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Partial Separation of Placenta

(duration) ? yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Phy and Examination

(Signed) Frank T Allen Norris, M. D.

, 19 (Address) Balto Md.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — Date of Burial 5/13 1929

20 UNDERTAKER: Wyland — ADDRESS 1717 Pulaski

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 45849

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 45849

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Franklin Square Hospital, 14-26 Ward)

2-FULL NAME Preston St Leger Wright

(a) RESIDENCE NO. 1304 W Lexington St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Victoria Wright

6 DATE OF BIRTH (month, day, and year) Apr 7 - 1871

7 AGE Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
58	1	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Civil Engineer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer United States Government

9 BIRTHPLACE (city or town)
(State or country) Ohio

PARENTS

10 NAME OF FATHER Levi P. Wright

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ohio

12 MAIDEN NAME OF MOTHER Mary Funderburg

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ohio

14 Informant Mrs. Victoria Wright
(Address) 1304 Stafford. Balto.

15 Filed ... 19... HAMILTON JONES, M. D.
Registrar

MAY 12 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.
The CAUSE OF DEATH* was as follows:

Chronic Cardiac Disease

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas H Brooke M. D.

5/11, 1929 (Address) 3601 3rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL 5/13 1929

20 UNDERTAKER J. H. Cook — ADDRESS 1217 E Fayette St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 45850 31 E 45850

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1741 Sharp ST. 23-31 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Catherine Shea

(a) RESIDENCE NO. 1741 Sharp ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	widowed

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward J. Shea

6 DATE OF BIRTH (month, day, and year) Sept. 1, 1879

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
49	8	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Thomas Moulan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER unk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unk

14 Informant Marie F. Shea

(Address) 1741 Sharp St

MAY 12 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 1929, to May 9, 1929, that I last saw h. alive on May 9, 1929 and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C. M. Mulcahy, M. D.

5/12, 1929 (Address) 1779 William H

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cemetery

DATE OF BURIAL May 13th 29

UNDERTAKER Margaret J. Flynn

ADDRESS 1411 Light St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45851

CERTIFICATE OF DEATH

90 **E 45851**

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1300 N. Lexington ST., 14-26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie R Woodall

(a) RESIDENCE NO. 1300 N Lexington ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Harry Woodall

6 DATE OF BIRTH (month, day, and year): Jan 10 1853

7 AGE: Years 76 | Months 4 | Days 1 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: James Lamb

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Annie Baker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: James T Lamb

(Address) 1300 N Lexington St

15 Filed 5-14, 1926 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5-11-26

17 I HEREBY CERTIFY, That I attended deceased from 5/10, 1926, to 5/11, 1926, that I last saw h~ alive on 5/10, 1926 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Myocarditis chronic

Arteriosclerosis

Goitre chronic

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac dilatation acute

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? no

Signed) H Harry Woodall, M. D.

5/11, 1926 (Address) 11 N Carey St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Chestertown Md. DATE OF BURIAL: 5-13 1926

20 UNDERTAKER: Wm Chas A G Robb ADDRESS: 732 Edmondson Ave

Important. See instructions on back of certificate.

J.C.L. A.W.C.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45852

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

145-002

E 45852

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2422 E. Monument ST. 7-12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME VIOLA CURRY

(a) RESIDENCE NO. 2422 E. Monument ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Eric G. Curry

6 DATE OF BIRTH (month, day, and year) March 6, 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	2	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John Bauer

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Noethen

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mr. Eric G. Curry (Husband)

(Address) 2422 E. Monument St.

15 Filed MAY 21 1929 C. HARRISON JONES, M. D. Registrar

Par 1007

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1929 to May 10, 1929

that I last saw h[illegible] alive on May 10, 1929

and that death occurred, on the date stated above, at 9.45 p. m.

The CAUSE OF DEATH* was as follows:

Embolism Cardiac (Ant)

CONTRIBUTORY (Secondary) Pregnancy Hyst Forceps (duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes no Date of May 10/29

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) John Patrick M. D.

5/11, 1929 (Address) 936 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery

DATE OF BURIAL May 13, 1929

20 UNDERTAKER Henry Sander & Sons Inc

ADDRESS BALTIMORE ST. & BROADWAY.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45853

CERTIFICATE OF DEATH

109-402 E 45853

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 823 S. Paca St., 21-29 Ward)

2-FULL NAME Emma C. Mack

(a) RESIDENCE NO. 823 S. Paca St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 15 - 1923

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	6	3	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto. Md

PARENTS

10 NAME OF FATHER John J. Mack

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Anna Kraft

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto. Md.

14 Informant
(Address) John J. Mack 823 S. Paca St

Filed MAY 12 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Sepsis due to infected tonsils (Peritonsillar Abscess)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zollert M. D.

5/11, 1929 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL 5/13/29

UNDERTAKER Geo Leimbach & Son — ADDRESS 2132 Eastlnwood Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45854

CERTIFICATE OF DEATH

5V E 45854

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1133 Valley St., 10-14 Ward)

2-FULL NAME Francis A. Warner, M.D.

(a) RESIDENCE NO. 1133 Valley St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma W. Warner

6 DATE OF BIRTH (month, day, and year) Aug 29/1847

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	81	8	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Physician
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Francis A. Warner

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Talbott Co., Md.

12 MAIDEN NAME OF MOTHER Mary Jarvis

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto., Md.

14 Informant Mrs. Emma W. Warner
(Address) 1133 Valley St.

15 Filed MAY 12 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility-Rheumatism

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) F. H. Caeen M. D.

5/11/29 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem.	5/13 1929
20 UNDERTAKER Bile Niedfeld	ADDRESS Greenmount

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45855

CERTIFICATE OF DEATH

90

E 45855

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 618 N. Curley ST. 6-11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mildred E. Harrison

(a) RESIDENCE NO. 618 N. Curley St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Roland Harrison

6 DATE OF BIRTH (month, day, and year) Nov. 1-1898

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	30	6	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. 037

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cambridge

PARENTS

10 NAME OF FATHER Louis Mowbray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cambridge

12 MAIDEN NAME OF MOTHER B. Wright

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cambridge

14 Informant Roland Harrison

(Address) 618 N Curley St

15 Y 121929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May-11-1929

17 I HEREBY CERTIFY, That I attended deceased from March 15, 1929, to May 11, 1929, that I last saw her alive on May 11, 1929 and that death occurred, on the date stated above, at 1.30 p. m.

The CAUSE OF DEATH* was as follows:

Myocardial failure

(duration) yrs. 1 mos. 26 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) O. O. Trantham M. D.

, 19 (Address) 9 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cambridge Md	May 13 1929

20 UNDERTAKER John C. Miller

ADDRESS 2435 E. Oliver St

Important. See instructions on back of certificate.

E 45856

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 45856

1 PLACE OF DEATH

CITY OF BALTIMORE (No. 1119 Pine Heights Ave Violetville md) (ST.) (WARD) 25-12

2 FULL NAME Lillian C Dreuling

(Residence in Baltimore: No. 1119 Pine Heights Ave Violetville md) Sr.: 64 yrs. mos. ds.)

REGISTERED No. C 100-007

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female

4 COLOR OR RACE White

5 SINGLE, MARRIED WIDOWED OR DIVORCED (Write the word) Married

6 DATE OF BIRTH May (Month) 23 (Day), 1865 (Year)

7 AGE 63 yrs. 11 mos. 16 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Balto md

PARENTS

10 NAME OF FATHER Geo. Grove

11 BIRTHPLACE OF FATHER (State or country) Balto md

12 MAIDEN NAME OF MOTHER Mandy

13 BIRTHPLACE OF MOTHER (State or country) Balto md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Frank Dreuling

(Address) 1119 Pine Heights Ave

15 C. HAMILTON JONES, M. D.

REGISTRAR

MAY 12 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May (Month) 9 (Day), 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from April 21 .1929. to. May 9 1929.
that I saw h[illegible] alive on May 9 .1929.
and that death occurred, on the date stated above, at 10 P m.
The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(Duration) yrs. mos. 18 ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed). Edwin Rowin M. D.

May 10 .1929 (Address) 1703 Linden Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death	yrs.	mos.	ds.	In the State	yrs.	mos.	ds.

Where was disease contracted, if not at place of death?
Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Druid Ridge vault later Lorraine Mausoleum

DATE OF BURIAL 5 - 13 - 1929

20 UNDERTAKER H C Brannings Son

ADDRESS 1136 Boltar & Grove St

Every item of information should be carefully supplied. AGE should be stated EXACTLY in years, months and days. The CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45857

CERTIFICATE OF DEATH

129 E 45857

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3043 Brighton ST. 13-59 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baruch Wheeler Swezey

(a) RESIDENCE NO. 2126 Callow ave ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 6 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Willie Redlman Swezey

6 DATE OF BIRTH (month, day, and year) Oct 15. 1867

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
61	6	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Lady of Both

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER John H Swezey

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md

12 MAIDEN NAME OF MOTHER Sarah C Wheeler

13 BIRTHPLACE OF MOTHER (city or town) Balt
(State or country) Md

14 Informant Mrs M R Swezey
(Address) 2126 Callow ave

15 MAY 21 1929 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10/29

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 19 28, to May 10, 19 29, that I last saw him alive on May 10, 19 29, and that death occurred, on the date stated above, at 11.40 P. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) — yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Necropsy

(Signed) Herman F Hellman, M. D.

19 (Address) 6 East Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	May 13 1929

20 UNDERTAKER John B Spencer ADDRESS 1325 N. Caroline St

MAY 21 1929

Spec.—2-29-28—L. F. S.—500 Blks.

45858

E 45858

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 45858

1—PLACE OF DEATH Union Memorial Hospital — REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 33[illegible] Calvert ST. 22-32 WARD)

2—FULL NAME Dorothy Leona White

(a) RESIDENCE NO. Cherry Hill Westport, Maryland ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 18 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Infant

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 8 1928

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	0	10	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Westport, Maryland

PARENTS

10 NAME OF FATHER Charles White

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Ruth

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Mother Margaret White (Address) Westport Maryland

15 May 12 1929 C. HAMILTON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11th 1929

17

I HEREBY CERTIFY, That I attended deceased from May 9, 1929, to May 11, 1929, that I last saw her alive on May 11, 1929, and that death occurred, on the date stated above, at 8 20 p.m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) yrs. mos. 11 ds. +

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Lumbar Puncture

(Signed) Wallace P. Swartzwelder M. D.

5/11, 1929 (Address) Union Memorial Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	5/13 1929
20 UNDERTAKER Robert Brooks & Son	ADDRESS Calhoun Hollins st

Spec.—2-29-28—L. F. S.—500 Bks.

Meauley

E45859

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 45859

CERTIFICATE OF DEATH

1—PLACE OF DEATH Union Memorial Hospital. REGISTERED NO.

CITY OF BALTIMORE: (No. 33rd Calvert 17-49 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mr. Mortimer B Meauley

(a) RESIDENCE NO. Ruxton, Md. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. mos. 2 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wife Sue Hann Meauley

6 DATE OF BIRTH (month, day, and year) June 30th 1877

7 AGE	Years	Months	Days	If LESS than 1 day, — hrs. or — min.
51	22?	10	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pres. Jones Hollow ware Co.

(b) General nature of Industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia.

PARENTS

10 NAME OF FATHER Mr. John Meauley.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia.

12 MAIDEN NAME OF MOTHER Miss Betty William.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant L. M. Hann
(Address) 2 Somerset Road Roland

15 Filed ... 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/11/29

17 I HEREBY CERTIFY, That I attended deceased from May 9th, 1929, to May 11th, 1929, that I last saw him alive on May 11th, 1929, and that death occurred, on the date stated above, at 11:05 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood culture.

(Signed) Palmer F. C. Williams, M. D.

5/11, 1929 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	May 14th 1929
20 UNDERTAKER	ADDRESS
Thos J Meehan & Sons	Eutaw & Franklin Sts

131929 SUNOPSIS

Spec.—2-29-28—L. F. S.—500 Bks.

E 45860

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

8th E 45860

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 111 W. Monument ST. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Dammann Ogle

(a) RESIDENCE NO. 111 W. Monument St. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred About 71 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Benjamin Ogle

6 DATE OF BIRTH (month, day, and year) About 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About 71		-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER F. William Dammann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary E. MacDonald

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Aileen D. Ingraham

(Address) 111 W. Monument St.

131929 C. HAMPSON JONES, M. D.

Registrar

Date

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12th 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 1st, 1929, to May 12th, 1929

That I last saw h[illegible] alive on May 11th, 1929

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Disease

Myocardial Insufficiency.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) J. C. Hampson Jones, M. D.

May 13 1929 (Address) 800 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lohdon Park Cemetery

DATE OF BURIAL May 14 29

20 UNDERTAKER Henry W. Meyer & Son

ADDRESS 805 N. Calvert St.

Spec.—1-12-23—M&T—500 Bks.

45861

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 45861

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1208 E Lafayette Ave ST., 4-18 WARD)

2-FULL NAME Charles R Scharf.

(a) RESIDENCE No. 1208 E Lafayette Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Catherine T Scharf

6 DATE OF BIRTH (month, day, and year) June 30 - 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	78	10	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired R R Conductor

(b) General nature of industry, business, or establishment in which employed (or employer) 073

(c) Name of employer Penn R R Co

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Scharf.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Catherine T Scharf
(Address) 1208 E Lafayette Ave

15 Filed ..... 19 HARRISON JONES, M. D. Registrar

AY 131929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12th 1929

17 I HEREBY CERTIFY, That I attended deceased from May 1 1928 to May 12th 1929.

that I last saw him alive on May 10th 1929.

and that death occurred, on the date stated above, at 6 30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart disease

(duration) 1 yrs. mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted, if not at place of death? ✓

Did an operation precede death? ✓ Date of

Was there an autopsy? ✓

What test confirmed diagnosis?

(Signed) Samuel Steinberg, M. D.

19 (Address) 3735 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem — DATE OF BURIAL May 14 1929

20 UNDERTAKER Wm C Cook — ADDRESS 1717 St Paul

TION is very important See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 45862

HEALTH DEPARTMENT—CITY OF BALTIMORE

118 E 45862

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Balto. Co. ST. ... WARD ...

2-FULL NAME Charles Pyatt

(a) RESIDENCE No. 1240 W. Potomac St. ST. ... WARD ...

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Febry 14-1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	59	2	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Huckster

(b) General nature of industry, business, or establishment in which employed (or employer) Own

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Chas Pyatt

11 BIRTHPLACE OF FATHER (city or town) South
(State or country) Carolina

12 MAIDEN NAME OF MOTHER Ida L. Mitchell

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant Mrs M R Michael
(Address) 252 E Hoffman

15 Filed MAY 13 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/11/29

17 I HEREBY CERTIFY, That I attended deceased from 5/11/29, 19..., to 5/11, 1929, that I last saw him alive on 5/11, 1929 and that death occurred, on the date stated above, at 12 01 m

The CAUSE OF DEATH* was as follows:

Strangulated Hernia
with Gangrenous
and perforated intestine

(duration) ... yrs. ... mos 3 ds.

CONTRIBUTORY
(Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 5/11/29

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Benj. Sanders M. D.

, 19 (Address) West Balto. Co. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimor County

DATE OF BURIAL 5/13 1929

20 UNDERTAKER W M Cook

ADDRESS 1217 St Paul

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45863 — CERTIFICATE OF DEATH — E 45863

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS — REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 11-24 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Virgie Coats

(a) RESIDENCE NO. 946 Linden Ave. ST., ... WARD 8a
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. 6 mos. ..... ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Separated

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Alex Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Louise Pate

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Records of

(Address) Baltimore City Hospitals

15 Filed MAY 13 1929 [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 9, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 22, 1929, to May 9, 1929, that I last saw her alive on May 9, 1929 and that death occurred, on the date stated above, at 11:25 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial nephritis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? Laboratory

(Signed) [illegible], M. D.

, 19 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
South Boston Va.	May 13 1929
20 UNDERTAKER: Mrs. R. G. Elliott	ADDRESS: 175 Ashland Ave

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45864 CERTIFICATE OF DEATH × 129 **E 45864**

1—PLACE OF DEATH University Hosp REGISTERED NO.

CITY OF BALTIMORE: (No. 4-30 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Isabell Dewar

(a) RESIDENCE NO. ST., WARD Phoenix Md.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single.

6a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 18 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work nurse ret

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D. C.

PARENTS

10 NAME OF FATHER Donald. Dewar

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Christiana Kennedy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland.

14 Informant Mrs. Margaret D. Harrell (Address) New Market, Md

15 Filed MAY 13 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12th 1929

17 I HEREBY CERTIFY, That I attended deceased from May 4th, 1929, to May 12th, 1929, that I last saw her alive on May 12th, 1929, and that death occurred, on the date stated above, at 1 1 m.

The CAUSE OF DEATH* was as follows:

Uraemia

acute proctosigmoiditis

amebic

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Chronic nephritis

(duration) (?) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Phoenix Md

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. G. Warner, M. D.

(Address) Univ. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Boonsboro Cemetary — DATE OF BURIAL May 15 1929

20 UNDERTAKER Chas. D. Bast & Son — ADDRESS Boonsboro Md

IMPORTANT.—See instructions on back of certificate.

Cor.—12-9-25—A Co.—260 Bks.

E 45865

HEALTH DEPARTMENT—CITY OF BALTIMORE

66

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED E 45865

City of BALTIMORE: (No. 1722 Lytton St. 25-72 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alonzo A. Stayler

(a) RESIDENCE NO. 1722 Lytton St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. 5 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

OF DEATH In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Mary E. Stayler

6 DATE OF BIRTH (month, day, and year): Dec 9 1872

7 AGE — Years: 56 Months: 5 Days: 1 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Bricklayer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER: Alonzo A. Stayler

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Baltimore

14 Informant: Viola Jeffers

(Address) 1722 Lytton St

15 Filed 1929 C. HAMPSON JONES, M. D. Registrar

Pat

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 10 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to L death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) Chas. H. Broosle M. D.

(Coroner)

5/10, 1929 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem. Date of Burial 5/13 1929

20 UNDERTAKER: Edward Lawton ADDRESS 2357 Wash

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 45866

E 45866

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Balto. City Hosp. ST. 7-1-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Moran

(a) RESIDENCE NO. 602 Parkin ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fish peddler

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Edmond Moran

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Johanna ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Jane Schwartz

(Address) 602 Parkin St

15 Filed ..., 19... L. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/11/29

17

I HEREBY CERTIFY, That I attended deceased from 5/9, 19 29, to 5/11, 19 29.

that I last saw h.. alive on 5/11, 19 29

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach with metastasis to liver

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. U. Pumphrey, M. D.

5/12, 1929 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Calvary	5/14 1929
20 UNDERTAKER	ADDRESS
Edward Toulon	2359 Washington Blvd

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45867

CERTIFICATE OF DEATH

31

E 45807

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) Baltimore City Hospitals ST., (T. B. 7-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lucille Wilson

(a) RESIDENCE NO. 923 Argyle ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1907

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	22			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 010

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Richard Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Travers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records

(Address)

15 Filed MAY 13 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 6, 1929, to May 9, 1929, that I last saw her alive on May 9, 1929 and that death occurred, on the date stated above, at 2.15 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Lab. Clinical Path.

(Signed) Henry Smith M. D.

5-9-, 19 29 Address Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Dulaney Dell 5-13 1929

20 UNDERTAKER — ADDRESS

Sand Eaton, Kane 916

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 45868

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

84 ~ E 45868

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St. 4-26 Ward)

2-FULL NAME William Wade

(a) RESIDENCE NO. 332 Pine St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	48			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

040

9 BIRTHPLACE (city or town)
(State or country) N. C.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Mr. M. E. Brown
(Address) 332 Pine St.,

15 Filed MAY 13 1929 HAMPSON JONES, M. D. Registrar

1004

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11, 1929. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Angina Pectoris.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Eugene Feller, M. D.

5/12. 1929 (Address) 2739 Eastern Ave.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dr. Cockeysville

DATE OF BURIAL 5-13 1929

20 UNDERTAKER David Carter

ADDRESS 716 Lanvale

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45869 — CERTIFICATE OF DEATH — E 45869

1-PLACE OF DEATH

City of Baltimore: (No. South Baltimore General Hospital Ward) 24-33 188-203

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph F. Seibert.

(a) RESIDENCE NO. Florida Ave Balto. Highlands, Balto Co. Md.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) October 16, 1878

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	55	6	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Jacob E. Seibert.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany.

12 MAIDEN NAME OF MOTHER Augusta Epple.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany.

14 Informant Catherine Bauer. (sister)
(Address) Florida Ave. Balto Highlands

15 Filed ..... 19.. C. HARRISON JONES, M. D., Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull, struck and knocked down by an Automobile

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) Accidental Death

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. M. Reinhardt, M. D.

5/18, 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem. — DATE OF BURIAL 5/13 1929

20 UNDERTAKER Mr. & Mrs John W. Taylor — ADDRESS 1128 W. Fayette St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec. –7-17-26—A Co.—200 Bks.

45870

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 45870

1-PLACE OF DEATH Mercy Hospital

REGISTERED NO.

City of BALTIMORE: (No. ... St. ... Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary Becker

(a) RESIDENCE NO. Harford Rd & Gingamore St. Ward

(Usual place of abode) (Family)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, ~~Widowed, or Divorced~~, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis M. J. Becker

6 DATE OF BIRTH (month, day, and year) Dec. 10 1875

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min..
54	53	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) " 37

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER George Green

11 BIRTHPLACE OF FATHER (City or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Alice V Green

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Louis M. J. Becker (Address) Harford & Gingamore

15 Filed ..., 19.. C. HAMPSON JONES, M. D. Registrar

MAY 13 1929 Dist.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

5-10-29

17 I HEREBY CERTIFY, That I attended deceased from 5/9/29, 19.., to 5-10-29, 19.., that I last saw her alive on 5-10-29, 19.., and that death occurred, on the date stated above, at 4.45 P m.

The CAUSE OF DEATH* was as follows:

Chronic Glomerular Nephritis

(duration) ... yrs. ? mos. ... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis - Hypertension

(duration) ... yrs. ? mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Leyko, M. D.

5/10/29 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — Date of Burial May 14 1929

20 UNDERTAKER John A Moran — ADDRESS 3050 E Balto

DO NOT should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45871

CERTIFICATE OF DEATH.

49 E 45871

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1020 N. Fulton Ave ST. 16-27 (WARD)

2-FULL NAME John H. Cook

(a) RESIDENCE NO. 1020 N. Fulton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
Male	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Caroline Cook,

6 DATE OF BIRTH (month, day, and year) October 7. 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	67	7	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Captian of ?

(b) General nature of industry, business, or establishment in which employed (or employer) Fire Department

(c) Name of employer B?.F.D.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Frank Cook,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Martha ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Caroline Cook, (Address) 1020 N. Fulton Ave.

15 Filed . 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11th 1929

17 I HEREBY CERTIFY, That I attended deceased from January 28th, 1929, to May 11th, 1929, that I last saw him alive on May 11th, 1929, and that death occurred, on the date stated above, at 10-30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Left Cheek

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of

Was there an autopsy? No, (refused).

What test confirmed diagnosis? X ray and Laboratory

(Signed) H. A. Kraemer, M. D.

May 12 1929 (Address) 1929 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ Baltimore DATE OF BURIAL 19

20 UNDERTAKER Geo H. Little ADDRESS

MAY 13 1929

C. HARRISON JONES, M. D.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45872

CERTIFICATE OF DEATH

89 E 45872

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 2210 W. North Ave. 5-66 (Hosp. or Inst.) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Ann Wells

(a) RESIDENCE NO. 2210 W. North Ave. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 88 yrs. 1 mos. 2 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Geo. Rusk Wells.

6 DATE OF BIRTH (month, day, and year): Apr. 8, 1841

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
88	1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None. D

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Robert A. Lambert

11 BIRTHPLACE OF FATHER (city or town) (State or country): Isle of Wight England

12 MAIDEN NAME OF MOTHER: Mary M. Darney

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Mr. Ralph A. Wells

(Address) 2216 Kathryn Ave.

15 FILED: 1929 HAMPSON JONES, M. D. Registrar

AD 131929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 10 1929

17 I HEREBY CERTIFY, That I attended deceased from 5-8 . 1929 . to 5-10 . 1929, that I last saw h alive on 5-10 . 1929 and that death occurred, on the date stated above, at 4.30 a.m.

The CAUSE OF DEATH* was as follows:

Uraemia

Chronic Interstitial Nephritis

Arterio Sclerosis

(duration) 1 week

CONTRIBUTORY (Secondary) Eczema Universal

(duration) Two Months yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Ina A. Fellows M. D.

5-11 . 1929 (Address) 3400 Wolfe Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cem. — DATE OF BURIAL: May 13 1929

20 UNDERTAKER: Wm. J. Pickney & Son — ADDRESS: Noel & Pa

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45873

CERTIFICATE OF DEATH

90

E 45873

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1219 Argyle St. 17-24 Ward)

2-FULL NAME Gussie Montgomery

(a) RESIDENCE NO. 1219 Argyle St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col

5 Single, Married, Widowed or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: unknown.

6 DATE OF BIRTH (month, day, and year): 1866

7 AGE: Years 62 | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Cook.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town): Md
(State or country)

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant: Lennie Porter
(Address) 1219 Argyle St.

15 Filed May 16 1929 H. A. JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 10 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) T. J. Leitch M. D.
May 10 1929 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: May 13 29

20 UNDERTAKER: Samuel A Hensley — ADDRESS: 1128 Bank

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-002

E 45874

1—PLACE OF DEATH

CERTIFICATE OF DEATH

REGISTERED NO. E 45874

CITY OF BALTIMORE: (No. 611 N Hoffman ST. 17-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph B Cole

(a) RESIDENCE NO. 611 N Hoffman ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1868

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
61	+		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St Mary's Co Md

PARENTS

10 NAME OF FATHER Alex Cole

11 BIRTHPLACE OF FATHER (city or town) (State or country) St Mary's Co Md

12 MAIDEN NAME OF MOTHER Nellie Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) St Mary's Co Md

14 Informant Lottie Holt
(Address) 519 Pierce St

15 Filed ..... 19 ..... HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11. 1929.

17 I HEREBY CERTIFY, That I attended deceased from April 25, 1929, to May 11, 1929, that I last saw him alive on May 10, 1929 and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema due to
acute Dilatation of Heart

(duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary) Arteria-Sclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) M. Edwin Porter, M. D.

5/13, 1929 (Address) 4822 Belair Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	May 14 1929
20 UNDERTAKER	ADDRESS
Samuel T. Hemsley	578 N Bridle

Important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 45875 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

11-001

E 45875

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 611 Green ST., 17-25 WARD)

2-FULL NAME Robt T. Dorsey

(a) RESIDENCE NO. 611 Green ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Dorsey

6 DATE OF BIRTH (month, day, and year): Aug 15 1886

7 AGE: Years 47 Months 8 Days 26 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Shoeworker

(b) General nature of industry, business, or establishment in which employed (or employer): Factory

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Andrew Dorsey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Lodney Mattox

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mary Dorsey

(Address) 611 Green St

15 Filed MAY 13 1929 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 11 1929

17 I HEREBY CERTIFY, That I attended deceased from 4/20, 1929, to May 11, 1929, that I last saw h[illegible] alive on May 10, 1929, and that death occurred, on the date stated above, at 7:40 P. M.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Pertussis Pneumonia

(duration) yrs. mos. 1 wk.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Lee Cole, M. D.

May 13, 1929 (Address) 524 Mond. Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: May 14 1929

20 UNDERTAKER: Samuel T. Hemsley — ADDRESS 578 N Bridle

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of disease is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 45876

1-PLACE OF DEATH

City of Baltimore: (No. 3438 Auchentorly Terr. 12-54 Ward)

2-FULL NAME Bernard Brown

(a) RESIDENCE NO 3438 Auchentorly St., Terrace Ward
(Usual place of abode)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? 21 yrs. mos. ds.

(If non-resident give city or town and State)

90

E 45876

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Deborah Brown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	64	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Russia

PARENTS

10 NAME OF FATHER Sholom Brown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Freda

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Jack Lewis
(Address) 1439 E. Baltimore

15 Filed MAY 13 1929 C. HARRISON JONES, M. D. Registrar
Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/12 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Coronary Disease of Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John F. Morrison, M. D.

5/13 1929 (Address) 263 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem

DATE OF BURIAL 5/13 1929

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E. Baltimore St

Not Should be carefully supplied. ... OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45877

CERTIFICATE OF DEATH

8-44 185

E 45877

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2925 Overland Ave St. 8 Ward)

2-FULL NAME Caroline Sehrt

(a) RESIDENCE NO. 2925 Overland Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Sehrt

6 DATE OF BIRTH (month, day, and year): May 4/1858

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	71	C	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): At home
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto., Md.

PARENTS

10 NAME OF FATHER: Henry Becker

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Louise -----

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Henry Sehrt
(Address): 2925 Overland Ave

15 Filed 5/13/29 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Hypostatic Pneumonia
Fracture Neck of left Femur.
Accidently fell in home.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. S. Bowen M. D.

5/11/29 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Pk — DATE OF BURIAL: 5/13 1929

20 UNDERTAKER: Philip J. Henry — ADDRESS: 2016 Orleans St.

MAY 13 1929

tion should be carefully supplied. Note should be taken of OCCUPATION is very important. See instructions on back of certificate. OF DEATH in plain terms, so that it may be properly classified. Exact statement of

Spec.—1-12-23—M&T—500 Blks.

45878

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45878

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO.) St. Agnes Hosp. (ST.) 21-24 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Margaret Thunder

(a) RESIDENCE. NO. 633 Tyrith St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: ~~Male~~ Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of or) ~~WIFE of~~ Christopher Thunder

6 DATE OF BIRTH (month, day, and year) March 17 1869

7 AGE: Years 60; Months 1; Days 25; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: ?

11 BIRTHPLACE OF FATHER (city or town) (State or country): ?

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ?

14 Informant: Christopher Thunder

(Address) 633 Tyrith St City

15 Filed MAY 13 1929 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5 - 12 1929

17 I HEREBY CERTIFY, That I attended deceased from 5-2, 1929, to 5-12, 1929.

that I last saw her alive on 5-12, 1929

and that death occurred, on the date stated above, at 5 55 a.m.

The CAUSE OF DEATH* was as follows:

Myocarditis Chronic

Nephritis Chronic Interstitial

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Physical.

(Signed) A. M. Erickson, M.D.

, 19 (Address) St Agnes Hosp Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral — DATE OF BURIAL: 5-15 1929

20 UNDERTAKER: Eyriard & Hark — ADDRESS: 1004 N Paca St

IMPORTANT. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Lewis

HEALTH DEPARTMENT—CITY OF BALTIMORE

Pl 7497

100-09

E 45879

CERTIFICATE OF DEATH.

E 45879 DEATH Franklin Square Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Calhoun & Fayette ST., 18-20 WARD)

2-FULL NAME Mrs. Eugenia Lewis

(a) RESIDENCE NO. 802 W. Lombard ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John A Lewis

6 DATE OF BIRTH (month, day, and year) Oct 7 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	7	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Howard County Md.

PARENTS

10 NAME OF FATHER John Elder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Howard Co Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Howard Co Md

14 Informant John A Lewis (Address) 802 W Lombard St

MAY 13 1929 C. HAMPSON JONES, M. D. Registrar

File No. 9

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1929

17 I HEREBY CERTIFY, That I attended deceased from May 6 , 1929, to May 12 , 1929, that I last saw her alive on May 12 , 1929, and that death occurred, on the date stated above, at 12 noon m.

The CAUSE OF DEATH* was as follows:

Generalized arterio sclerosis

Arthritis Deformans

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchio-pneumonia

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Elizabeth B Sherman, M. D.

5/12, 1929 (Address) Franklin Square Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lodge Wlf. Co. Northumberland Va DATE OF BURIAL May 15 1929

UNDERTAKER Owen Cook ADDRESS 1217 St Paul

c/o Beta and Del & Sts c/o John W Lewis

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupa-TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45880

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45880

CERTIFICATE OF DEATH

129

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1127 Orleans ST. 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Eliza Bell

(a) RESIDENCE NO. 1127 Orleans ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Richard Bell

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
50	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harvard Co Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Richard Bell

(Address) 1127 Orleans St.

15 Filed MAY 13 1929 Harrison Jones, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 1929

17

I HEREBY CERTIFY, That I attended deceased from April, 1929, to May 11, 1929, that I last saw h alive on May 9, 1929, and that death occurred, on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Chronic Parenchymatous Nephritis

(duration) 1 yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. J. Young, M. D.

5/12, 1929 (Address) 1429 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Calvary	May 13 1929
20 UNDERTAKER	ADDRESS
Mrs R. A. Elliott	1725 Aisquith

Important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 45881

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

135 E 45881

REGISTERED NO.

1-PLACE OF DEATH Provident Hospital

CITY OF BALTIMORE: (No.) 1514 Division ST., 9th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Morgan

(a) RESIDENCE NO. 1920 Ashburton ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Life 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Irene Morgan

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE: Years 50; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Janitor

(b) General nature of industry, business, or establishment in which employed (or employer): 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Atlantic City, N J

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Irene Morgan (Address) 1920 Ashburton st

15 [illegible] HAMPSON JONES, M. D. Registrar

AY 131929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1929, to May 11, 1929, that I last saw h[illegible] alive on May 11, 1929, and that death occurred, on the date stated above, at 8.30a. m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

Acute Primary Peritonitis

Leucemia

? (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Leucemia (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) B Hamm M. D.

5/11, 1929 (Address) Provident Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery — DATE OF BURIAL: May 14 1929

20 UNDERTAKER: Mrs. P. G. Elliott — ADDRESS: 17[illegible] Eutaw

CAUSE OF DEATH. TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45882

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 45882

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Carrie Prattis

(a) RESIDENCE NO. 724 Ensor ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Riley Prattis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Delaware

12 MAIDEN NAME OF MOTHER Lettie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Delaware

14 Informant Records of

(Address) Baltimore City Hospitals

15 Filed MAY 13 1929 19 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11, 1929

17 I HEREBY CERTIFY, That I attended deceased from January 25, 19 29, to May 11, 19 29,

that I last saw her alive on May 11, 19 29

and that death occurred, on the date stated above, at 3:10 A. m.

The CAUSE OF DEATH was as follows:

Broncho Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Hypertension — Emphysema ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam.

(Signed) Harrison M. D. Jones, M. D.

19 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cem. DATE OF BURIAL May 14 1929

20 UNDERTAKER Mrs J. J. Locks. ADDRESS 1382 Jefferson

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45883

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001

E 45883

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 923 Shuter ST., 1-13 WARD)

2—FULL NAME Rosa Vaughn

(a) RESIDENCE NO. 923 Shuter ST.,
(Usual place of abode)

WARD

Length of residence in city or town where death occurred yrs. mos. Life How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE C

5 Single, Married, Widowed, or Divorced, (write the word) S

a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE Years / Months 6 Days / If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby wd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Vaugh

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Lohr Jan.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant John Vaughn

(Address) 923 Shuter St.

15 Filed MAY 13 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 1929

17

I HEREBY CERTIFY, That I attended deceased from May 3, 1929 to May 11, 1929

that I last saw h alive on May 11, 1929

and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia
(Primary)

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) Geo. S. Allen M. D.

5-13-1929 (Address) 508 Somerset

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Leisbury Cem.

DATE OF BURIAL May 13 1929

20 UNDERTAKER Wm J. G. Locke

ADDRESS 1302 Jefferson

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

Johnson

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45884

CERTIFICATE OF DEATH

E 45884

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Balto City Hospital St. 2331 Ward)

2-FULL NAME Daisy Johnson

(a) RESIDENCE NO. 231 W Hill St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 15 1886

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	42	4	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Emmal Carter

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Essex Co. Va.

12 MAIDEN NAME OF MOTHER Daisy Carter

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto. Md.

14 Informant Margt Parker
(Address) 231 W. Hill Street

15 Filed MAY 13 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry.

thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) and from information above, and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage, Arteriosclerosis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 231 W Hill

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James W Pemberton, M. D.

May 11. 1929 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calary Cemetery — DATE OF BURIAL 5/13 1929

20 UNDERTAKER Walter B. Spriggs — ADDRESS 134 W. Hamburg St.

tion should be carefully supplied. A No. should be given for every house in which there is a death. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45885

CERTIFICATE OF DEATH.

101-01

E 45885

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital ST., WARD) 14-54

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Decatur Allen

(a) RESIDENCE NO. 2219 Druid Hill ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
14	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: student

(b) General nature of industry, business, or establishment in which employed (or employer): 0 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Washington, D.C.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Miles J. Allen

(Address) 2219 Druid Hill Ave

15 Filed MAY 13 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 10 1929

17

I HEREBY CERTIFY, That I attended deceased from May 6, 1929, to May 10, 1929, that I last saw h/ alive on May 10, 1929, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Undetermined

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) B Harris, M. D.

5/13 1929 (Address) Provident Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: May 13 1929

UNDERTAKER: Virginia A Brooks

ADDRESS: 1463 N Carey

CAUSE OF DEATH to print items, and write plainly with pen and ink. See instructions on back of certificates.

TION is very important.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 45886

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45886

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2621 Foster Ave St. 1-3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME... Annie Schillas

(a) Residence No. 2621 Foster Ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Female

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): Widow

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 1865

7-AGE: 64 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Austria

PARENTS.

10-NAME OF FATHER: dont know

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Austria

12-MAIDEN NAME OF MOTHER: dont know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Austria

14-

(Informant): Joshua Schaal

(Address): 2621 Foster Ave

15-

Filed MAY 13 1929

C. HAMPSON JONES, M.D. Registrar

By [illegible]

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 10 1929

17- I HEREBY CERTIFY, That I attended deceased from April 26, 1929, to May 10, 1929, that I last saw her alive on May 10, 1929, and that death occurred, on the date stated above, at 4.30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic nephritis, followed by left hemiplegia as result of apoplexy.

(Duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Pulmonary oedema

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) J. J. Sorin Haas M.D.

(Address) 3037 O'Donnell St

5-11-, 1929

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem

DATE OF BURIAL: May 14 1929

20-UNDERTAKER: Stephen J. Foltkowski Inc

ADDRESS: 1000 Kenwood Ave

Y 131929

In granting, do not write in this space. Instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 45887

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

E 45887

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) Mercy Hospital (Street) 2-8-6-4 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen Reardon

(a) RESIDENCE NO. 3-3-21 Lanvale St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Franklin B. Reardon

6 DATE OF BIRTH (month, day and year): August 25 - 1886

7 AGE: Years 42 Months 8 Days 17 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Balto.

(State or country): Md.

PARENTS

10 NAME OF FATHER: Patrick J. Gorman

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Canada

12 MAIDEN NAME OF MOTHER: Mary Blondell

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Balto

14 Informant: Franklin B. Reardon

(Address) 3-3-21 Lanvale St

Filed MAY 13 1929 H. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to h death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cystic Nephritis

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Embolism

(duration) yrs. mos. ds.

(Signed) A. J. O'Day M. D.

(Coroner)

May 13 29 (Address) 1429 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. State 7 in mmediate yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery Date of Burial: May 14 19 29

20 UNDERTAKER: Chas. P. Crane & Son ADDRESS 118 W. Mt. Royal Ave.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45888

CERTIFICATE OF DEATH

129

E 45888

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1612 Jefferson ST. 79 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jerome Jackson

(a) RESIDENCE NO. 1612 Jefferson ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Single.

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 1 1914

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	14	6	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Lloyd Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Amanda Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Amanda Jackson mother

(Address) 1612 Jefferson st

15 Filed 13 1929 By C. HAMPSON JONES, M. D. Registrar

Per Rule

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 1929

17 I HEREBY CERTIFY, That I attended deceased from March, 19 29 to May 11, 19 29, that I last saw h[illegible] alive on May 10, 19 29 and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency (Endocarditis)

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Pneumonia Nephritis Infectious Jaundice (duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R. J. Young, M. D.

5/12, 1929 (Address) 1429 Monument st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL asbury cemetery — DATE OF BURIAL may 15 1929

20 UNDERTAKER Edward Pierson — ADDRESS 1691 orleans st

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Blks.

E 45889

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

185 **E 45889**

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Agnes Hospital St. 20-70 Ward)

2-FULL NAME Horrace G. Childs

(a) RESIDENCE NO. 26 S. Culver St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Childs

6 DATE OF BIRTH (month, day, and year) Oct 20, 1875

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	54	6	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House Painter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER George T. Childs

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore, Md

12 MAIDEN NAME OF MOTHER Harriet Childs

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore Md

14 Informant Mrs. Mary Childs
(Address) 26 S Culver St.

15 Filed MAY 13 1929 C. HAMPSON JONES, M. D. Registrar
Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull. from fall off Step at 3453 Old Frederick Road. Blood Clot or brain possible (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. H. Brosius, M. D.

5-13, 1929 (Address) 3601 3rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL 5/15/29

20 UNDERTAKER Cook

ADDRESS 3631 Bank

This should be carefully supplied. It should be filled out by a physician. Cause of DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45890

CERTIFICATE OF DEATH

101-001

E 45890

1—PLACE OF DEATH

REGISTERED NO. 15-68

CITY OF BALTIMORE: (No. 2433 W. Northern ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary M. Wood

(a) RESIDENCE NO. 2433 W. Northern ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 61 yrs. 11 mos. 26 ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 16-1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	11	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dress Maker 069

(b) General nature of industry, business, or establishment in which employed (or employer) Alteration Dept.

(c) Name of employer Hutzler Bros

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Joshua Wood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sallie Musgrove

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs. Samuel B. Whitford

(Address) 2433 W. Northern

15 [illegible] HAMPSON JONES, M. D. Registrar

MAY 13 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12-1929

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1929, to May 12, 1929, that I last saw her alive on May 12, 1929 and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Heart failure - Auricular fibrillation (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical findings

(Signed) Maurice E. Shamer, M. D.

5/14, 1929 (Address) 3300 W. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	May 14 1929
20 UNDERTAKER	ADDRESS
Harry W. Ehlen	1944 N. North Ave.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45891 CERTIFICATE OF DEATH 162 **E 45891**

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1102 S. Bouedin ST. 1-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry W. Lang. Jr

(a) RESIDENCE NO. 1102 S. Bouedin ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 5-1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md

PARENTS

10 NAME OF FATHER Henry W. Lang

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary Rhoades

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Henry W. Lang

(Address) 1102 S. Bouedin St

15 Filed JUN 13 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13-1929

17

I HEREBY CERTIFY, That I attended deceased from May-12-, 1929, to May-13-, 1929, that I last saw him alive on May-13-, 1929, and that death occurred, on the date stated above, at 9 a. m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) N. J. Dandor, M. D.

, 19 (Address) 3035-Edmondson Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cem. DATE OF BURIAL May 14 1929

20 UNDERTAKER George W. Zirkler ADDRESS 1737 E. Eager St

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 45892

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 45892

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore (No.) Rear front 3404 Wabash Ave (Ward) 27

2-FULL NAME Jas. Letty (Gunn)

(a) RESIDENCE NO. 1942 Laurella Ave St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of No.

6 DATE OF BIRTH (month, day, and year) 1898 Jan 20

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	31	3	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) West Indies.
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Mary Hall
(Address) 1942 Laurella Ave

Filed MAY 13 1929 HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of Vertebra and Suffocation

(duration) Sudden

CONTRIBUTORY (Secondary) Working in ditch. Earth fell on him.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Rear 3404 Wabash Ave,

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) M. Welsh, M. D.

May 11th 1929 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery DATE OF BURIAL May 13 1929

20 UNDERTAKER George L. Schwab ADDRESS 701 Fulton Ave

Over

Now should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45893

CERTIFICATE OF DEATH.

E 45893

REGISTERED NO. 161-20

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Church Home & Infirmary

City of BALTIMORE: (No. 126 N. Bond Ward 16-19)

2-FULL NAME Baby Boy Sealover.

(a) RESIDENCE NO. 8 N. Highland St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 11/29.

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
30hrs		1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.

(State or country)

PARENTS

10 NAME OF FATHER Wm James Sealover

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore

12 MAIDEN NAME OF MOTHER Genevieve Smith

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore

14 Informant

(Address)

15 Filed ~~C. HAMPSON JONES, M. D.~~ 19

~~C. HAMPSON JONES, M. D.~~ Registrar

MAY 13 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1929.

17 I HEREBY CERTIFY, That I attended deceased from May 11 1929, to May 12, 1929, that I last saw h~~im~~ alive on May 12, 1929 and that death occurred, on the date stated above, at 10 30 p. m.

The CAUSE OF DEATH* was as follows:

Prematurity 6 3/4 mths

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Haemorrhage new Born (duration) yrs. mos. 1 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D B Peeler, M. D.

, 19 (Address) Church Home & Infirm

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Church Home & Infirmary Date of Burial 19

20 UNDERTAKER ADDRESS

Commissioner Health.

MAY 13 1929

Y 13 1929

For Registrar's Use Only. Any Alteration or Erasure Renders Certificate Void. OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 45894 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45894

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4608 Park Hgts. Ave. WARD)

2-FULL NAME Infant of- Mr. & Mrs. Wm E. Burton

(a) RESIDENCE NO. 4608 Park Hgts Ave. WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(if non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) May 9, 1929

7 AGE — Years | Months | Days | If LESS than 1 day 3 hrs or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md.

PARENTS

10 NAME OF FATHER Wm E. Burton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Delaware

12 MAIDEN NAME OF MOTHER Lillian M. Gray

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md

14 Informant Lillian M. Gray

(Address) 4608 Park Hgts. Ave

15 Filed MAY 13 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9 1929

17 I HEREBY CERTIFY, That I attended deceased from May 9, 1929, to ....., 19 29

that I last saw h.. alive on May, 19 29

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(5 mo)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Prematurity

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) W. E. Campbell, M. D.

5/10 1929 (Address) 1644 Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL May 11 1929

20 UNDERTAKER Dept. Outdoor Health. — ADDRESS .....

CAUSE OF DEATH: ATTENTION is very important See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 45895

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-021

E 45895

CERTIFICATE OF DEATH

1-PLACE OF DEATH Enroute

City of Baltimore: (No.) Hopkins Hospital St., 7-1 Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nicola Kolts

(a) RESIDENCE NO. 722 S. Broadway St., Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
about 50			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Seaman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Esthonia
(State or country) Russian-Finland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) "
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) "
(State or country)

14 Informant Eastern Police District
(Address)

15 Filed ..... 19.. C. HAMPSON JONES, M. D. Registrar

MAY 13 1929

3370 THE MORGUE

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Pneumonia (Lobar)

..... (duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary) Alcoholism

..... (duration) ..yrs. ..mos. ..ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. J. Walker, M. D.

5/8/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL ..... 19..

20 UNDERTAKER

ADDRESS

UNIVERSITY OF MARYLAND

Commissioner of Health.

MAY 13 192

Per Wm. E. WOODALL

Cor.—10-10-29—A Co.—100 Bks.

E 45895

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 45895

1-PLACE OF DEATH

City of Baltimore: (No. Enroute Hopkins Hospital St., 7-1 Ward)

2-FULL NAME Nicola Kolts

(a) RESIDENCE NO. 722 S. Broadway St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

(If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
about 50			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Seaman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Esthonia
(State or country) Russian-Finland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) "
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) "
(State or country)

14 Informant Eastern Police District
(Address)

15 Filed ..... 19.. C. HAMPSON JONES, M. D. Registrar

MAY 13 1929

3370 THE MORGUE

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 4/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Pneumonia (Lobar)

..... (duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary) Alcoholism

..... (duration) ..yrs. ..mos. ..ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. J. Walker, M. D.

5/8/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL ..... 19..

20 UNDERTAKER

ADDRESS

UNIVERSITY OF MARYLAND

Commissioner of Health.

MAY 13 192

Per Wm. E. WOODALL

tion should be carefully supplied. AGE should be stated EXACTLY. If less than one day, state hours or minutes. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45896

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

152 E 45896

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital WARD) REGISTERED NO. 21-29

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Blum

(a) RESIDENCE NO. 1236 W. Cross ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 5 mos. 21 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 19, 1928

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Clarence Blum

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Mary Spindler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Clarence Blum

(Address) 1236 W. Cross St.

15 Filed [illegible] 19 C. HAMPSON JONES, Registrar

Y 131029

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 24, 1929, to May 10, 1929, that I last saw h[illegible] alive on May 10, 1929 and that death occurred, on the date stated above, at 7:10 p.m.

The CAUSE OF DEATH* was as follows:

Malnutrition (improper feeding)

8

(duration) yrs. 5 mos. 21 ds.

CONTRIBUTORY (Secondary) Immunization (Staphylococcus Vaccine)

(duration) yrs. mos. 18 ds.

18 Where was disease contracted if not at place of death? 1236 W. Cross St.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Addison Craft [illegible] M. D.

5-13 1929 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL [illegible] NS HOPKINS HOSPITAL

DATE OF BURIAL . 19

20 UNDERTAKER [illegible] Commissioner Health

ADDRESS

MAY 23 1929

Important. See instructions on back of certificates.

Spec.—2-29-28—1. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45897

CERTIFICATE OF DEATH

E 45897

1—PLACE OF DEATH

REGISTERED NO. 20-64 29

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2506 W. FAIRMOUNT AVE. WARD)

2—FULL NAME Clara F. Schaeffer

(a) RESIDENCE NO. 2506 W. FAIRMOUNT AVE WARD

(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. 1 mos. 17 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 ~~SEX~~ Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of John F. Schaeffer

6 DATE OF BIRTH (month, day, and year) Nov 24th 1866

7 AGE Years 63 Months 1 Days 17 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Peter Kaupp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Clara Baumgard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Clarence E. Schaeffer

(Address) 2506 W. Fairmount Ave

15 Filed 1/31/29 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10th 29

17 I HEREBY CERTIFY, That I attended deceased from April 19, 1929, to May 10, 1929

that I last saw h[illegible] alive on May 10 1929

and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Myocarditis. Chr.
Interstitial Nephritis

CONTRIBUTORY (Secondary) Pulmonary Oedema (duration) [illegible] yrs. [illegible] mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Robert L. Weber, M. D.

(Address) 2506 W. Fairmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL May 15 1929

UNDERTAKER H. S. Wishart

ADDRESS 1850 W. Balto St

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45898

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-01 V

E 45898

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 536 S. Smallwood St (ST.) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Adelaide L. Kittel

(a) RESIDENCE NO. 536 S. Smallwood St

(Usual place of abode)

WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6 DATE OF BIRTH (month, day, and year): Feb 13th 1929

7 AGE: Years — Months 3 Days 9 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

8a If married, widowed, or divorced HUSBAND of (or) WIFE of —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Chas G. Kittel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Gertrude M. Walter

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Chas G. Kittel

(Address) 536 S. Smallwood St

15 DATE RECEIVED: MAY 13 1929

C. HAMPSON JONES, M. D. Registrar

Per ack

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 12/29

17 I HEREBY CERTIFY, That I attended deceased from May 11, 1929, to May 12, 1929, that I last saw her alive on May 12, 1929, and that death occurred, on the date stated above, at 7:10 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

Lobar Pneumonia (duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical and

(Signed) Jas. L. Kemp M. D.

5/13, 1929 (Address) 17 W. Saratoga St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: May 14th 1929

20 UNDERTAKER: J. B. Hufford — ADDRESS: 1850 N. Bolton St

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45899

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

99-12

E 45899

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1510 Bolton ST., 14-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ellen Boyd Findlay

(a) RESIDENCE NO. 1510 Bolton ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (write the word)
Female	White	Single

5a If ~~married, widowed~~, or ~~divorced~~
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 30 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
78 7 13	79			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Charles Findlay

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington D. C.

12 MAIDEN NAME OF MOTHER Elizabeth H Boyd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mrs Findlay French (Address) 1510 Bolton

15 131929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1929

17 I HEREBY CERTIFY, That I attended deceased from April 15 1929 to May 13 1929 that I last saw h e alive on May 13 1929 and that death occurred, on the date stated above, at 7 30 P.M.

The CAUSE OF DEATH* was as follows:

Myocarditis Senility (Senile Debility)

(duration) yrs. 1 mos. 2 ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) J. A. Chatard, M. D.

May 13. 1929 (Address) 1300 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	May 15 1929
20 UNDERTAKER Henry Jenkins & Sons Co	ADDRESS Orchard & Mc Collough

important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45900

CERTIFICATE OF DEATH

85 E 45900

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Md. Gen. Hospital 27-48 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Mary C. Baker

(a) RESIDENCE NO. 512 Rectory Lane Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. (If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 13, 1854

7 AGE Years 74 Months 10 Days 28 IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Pa.

(State or country)

PARENTS

10 NAME OF FATHER Henry Baker

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Susan Baker

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Pa.

14 Informant Mrs. Ora Baker

(Address) Hospital Records

Filed C. HAMPSON JONES, M. D. Registrar

By RCH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 May 11 1929

17 I HEREBY CERTIFY, That I attended deceased from 4-1, 1929, to 5-11, 1929 that I last saw h-r alive on 5-11, 1929 and that death occurred, on the date stated above, at 11.20 P. m.

The CAUSE OF DEATH* was as follows:

Fractured Femur (left)

(duration) yrs. 1 mos. 15 ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Lloyd Tompkins M. D.

5/11/29 (Address) 1 E. Lexington St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — Date of Burial: May 15 1929

20 UNDERTAKER: Horace H. Burgee — ADDRESS: 1631 Fulton Ave

Y 131929

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45901 100-001 E 45901

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1330 Morling Ave ST., 13 WARD)

2—FULL NAME Cameatia P. Bull

(a) RESIDENCE NO. 1330 Morling Ave ST., 13 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. — mos. 26 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 15-1928

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	—	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Emmitt N. Bull

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Cameatia B. Shannon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Emmitt N. Bull

(Address) 1330 Morling Ave.

15 Filed MAY 13 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11-1929.

17 I HEREBY CERTIFY, That I attended deceased from May 5th, 1929, to May 11th, 1929,

that I last saw her alive on May 10th, 1929

and that death occurred, on the date stated above, at 6th A. m.

The CAUSE OF DEATH* was as follows:

1 Broncho Pneumonia (Primary)

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Joseph Duncan M. D.

May 13 1929 (Address) 846 W Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet — DATE OF BURIAL May 14 1929.

20 UNDERTAKER Horace F. Burgee — ADDRESS 363 Fallsroad

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 45902 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

32 E 45902

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. 18-29 (WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geraldine Kipe

(a) RESIDENCE No. 1025 W. Balto ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 5th 1928

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Edward Kipe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ada Powell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1929

17 I HEREBY CERTIFY, That I attended deceased from April 16, 1929, to May 12, 1929, that I last saw her alive on May 12, 1929, and that death occurred, on the date stated above, at 7.50 P m.

The CAUSE OF DEATH* was as follows:

~~Whooping Cough associated with Tuberculosis~~

Tuberculous meningitis (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) ~~Tuberculous Meningitis~~ Pertussis (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) S. C. Goodwin, M. D.

5/13, 1929 Address Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Knollwood Sub

DATE OF BURIAL May. 15th 1929

20 UNDERTAKER Chas. B. Cook

ADDRESS 1003 N. Calvert St.

Y 131929

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bka.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45903 **E 45903**

CERTIFICATE OF DEATH.

128

1-PLACE OF DEATH

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 629 E. Fort Ave. St.) 24-34 (WARD)

2-FULL NAME August Joseph Eckert

(a) RESIDENCE. No. 629 E. Fort Ave. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Theresa Robinson

6 DATE OF BIRTH (month, day, and year) Feb. 25th 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	85	2	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Pipe-fitter

(b) General nature of industry business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Edward Eckert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Mary Kline

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant (Address) Mrs. A. J. Eckert 629 E. Fort Ave.

15 Filed ....., 19.... C. HAMPSON JONES, M. D. Registrar.

By .....

131929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11th 1929

17 I HEREBY CERTIFY, That I attended deceased from May 7. 1929. to May 11. 1929.

that I last saw him alive on May 9. 1929.

and that death occurred, on the date stated above, at 8:30 A. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchial Pneumonia

(duration) yrs. mes. 1 ds.

CONTRIBUTORY (Secondary) Acute Nephritis (duration) yrs. 6 mos. ds. (Chronic)

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. F. Hagerstown, M. D.

5/13 1929 (Address) 1 E. Ronalds St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Joseph's Cemetery, Gallatin	5/14, 1929

20 UNDERTAKER E. J. Fanning ADDRESS 1386 E. Lafayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45904

CERTIFICATE OF DEATH

E 45904

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1724 Dukeland St., 15-66 Ward)

2-FULL NAME Richard Wendell.

(a) RESIDENCE NO. 1724 Dukeland St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. 6 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 7th 1929

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
		11	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Geo. Wendell

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER Louise Rinehart

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14 Informant Louise Rinehart
(Address) 1724 Dukeland

15 Filed MAY 13 1929 G. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) May 13th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to (his) death on the day stated above.
The CAUSE OF DEATH* was as follows:

Acute Intestinal Obstruction

(duration) ..... yrs. One day

CONTRIBUTORY (Secondary) do

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Surgery

(Signed) C. B. Lewis, M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Middleburg Md — DATE OF BURIAL May 16th 1929

20 UNDERTAKER A. Jones — ADDRESS 116 S Gilmor

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 45905

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

168

E 45905

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Edgewood Sanitorium St. 1-W Ward)

2-FULL NAME FLORENCE SCHWESSINGER

(a) RESIDENCE NO. 136 S. Potomac St. _____ Ward _____
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of - - -

6 DATE OF BIRTH (month, day, and year) September 7,1872

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	56	7	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Varsity Underwear Co.

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER George Schwessinger

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Appel

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mr. Benjamin Schwessinger (Bro.)
(Address) 136 S. Potomac St. M D
C. HAMILTON JONES

Filed _____ 19____ Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11, 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an 5-11-29 (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Strangulation
Hanging by neck with
bath robe cord. Suicide

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mental Deranged

(duration) yrs. mos. ds.

(Signed) John Morrison M. D.
(Coroner)

5/5, 19 29 (Address) 3832 Roland ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel Cemetery — Date of Burial: May 14, 1929

20 UNDERTAKER: Henry Sander & Sons, Inc. — ADDRESS: BALTIMORE ST. & BROADWAY.

13 1929

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state cause OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45906

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-00

E 45906

1—PLACE OF DEATH

BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE: (No. ... ST., 1-3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lillian Wodbruck

(a) RESIDENCE NO. 601 So. Bradford ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ... mos. ... ds. How long in U. S., if foreign birth? — yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Wodbruck

6 DATE OF BIRTH (month, day, and year) Sept. ? 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) ? Md.

PARENTS

10 NAME OF FATHER Robert Clark ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Lena Clark ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Records ?

(Address) BALTIMORE CITY HOSPITALS

15 MAY 13 1929 C. HAMPSON JONES, M. D. Registrar

Reg'd

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-11-29

17 I HEREBY CERTIFY, That I attended deceased from 5-10, 1929, to 5-11, 1929, that I last saw h[er] alive on 5-11-, 1929 and that death occurred, on the date stated above, at 9:30 P (PM) m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia, Bilateral

(duration) ... yrs. ... mos. 6 ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Harvey H. McLaus, M. D.

, 19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cemetery	May. 15. 1929
20 UNDERTAKER Henry Sander & Sons Inc	ADDRESS Baltimore St. & Broadway.

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 45907

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

E 45907

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3010 St. Paul ST., 12-5D WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Francis Bickley Payne

(a) RESIDENCE NO. 3010 St. Paul ST., 12 WARD
(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. 0 mos. 0 ds. How long in U. S., if foreign birth? 55 yrs. 1 mos. 29 ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of (Single)

6 DATE OF BIRTH (month, day, and year) March 13 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55	1	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Accountant

(b) General nature of industry, business, or establishment in which employed (or employer) Bell Foundry

(c) Name of employer McShane Co.

9 BIRTHPLACE (city or town) (State or country) Richmond Virginia

PARENTS

10 NAME OF FATHER Dr. John M. Payne

11 BIRTHPLACE OF FATHER (city or town) (State or country) Buckingham Virginia

12 MAIDEN NAME OF MOTHER Betty Nash

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Richmond Virginia

14 Informant Miss Elsie M. Payne Sister

(Address) 3010 St. Paul St. City

15 MAY 14 1929, 19 ..... Per C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 24, 1929, to May 12, 1929

that I last saw h[illegible] alive on May 11, 1929

and that death occurred, on the date stated above, at 5-A. m.

The CAUSE OF DEATH* was as follows:

Fibrous Myocarditis

(duration) Years ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) 0 yrs. 0 mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Gustavus C. Dohme, M. D.

5/12, 1929 (Address) 3014 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	May 14 1929.

20 UNDERTAKER ADDRESS

Stewart & Moses Company Balto.

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45908

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49

E 45908

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4804 Park Heights ST. (WARD) 27-56

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Yates Perot

(a) RESIDENCE NO. 4804 Park Heights Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. 7 mos. 4 ds. How long in U. S., if foreign birth? 70 yrs. 7 mos. 4 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Caroline E. Perot

6 DATE OF BIRTH (month, day, and year): Oct 8 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70	7	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Balto. Maryland

PARENTS

10 NAME OF FATHER: Wm S. Perot

11 BIRTHPLACE OF FATHER (city or town) (State or country): England England

12 MAIDEN NAME OF MOTHER: Ann Hood

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bermuda

14 Informant: Mrs Caroline E Perot (wife)

(Address) 4804 Park Heights Ave

15 Filed 1 31929 19 Bur. C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 11 - 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 5 - 1928 to May 11 - 1929

that I last saw him alive on May 11 - 1929

and that death occurred, on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH* was as follows:

Duration

Carcinoma of Larynx

Metastasis to cervical glands.

Contributory Arteriosclerosis (duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Larynx (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Dx.

(Signed) James S. Ashehurst, M. D.

5-12-1929 (Address) 4012 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Hill Cemetery	May 14 1929
20 UNDERTAKER: Stewart & Morse Co.	ADDRESS: Balto.

important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks

E 45909

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45909

CERTIFICATE OF DEATH

1-PLACE OF DEATH — REGISTERED NO. 1561

City of BALTIMORE: (No. Maryland General Hospital St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Vincent Richardson

(a) RESIDENCE NO. 3400 Windsor Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: [illegible]

6 DATE OF BIRTH (month, day, and year): July 27. 1893

7 AGE — Years: 35 Months: 9 Days: 16 IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Teacher

(b) General nature of industry, business, or establishment in which employed (or employer): Kindergarden

(c) Name of employer:

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md

PARENTS

10 NAME OF FATHER: James A. Richardson

11 BIRTHPLACE OF FATHER (City or town): Balto

(State or country): Md.

12 MAIDEN NAME OF MOTHER: Fanny Ford

13 BIRTHPLACE OF MOTHER (city or town): Balto

(State or country): Md

14 Informant: Hospital Records

(Address)

15 Filed [illegible] C. HAMPSON JONES, M. D. Registrar

Per [illegible]

Y 131929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: May 13 1929

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1929, to May 13, 1929, that I last saw h[illegible] alive on May 13, 1929, and that death occurred, on the date stated above, at 9 00 a.m.

The CAUSE OF DEATH* was as follows:

Intra. thrombosis of Coronaries.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of May 6-1929

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

(Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — Date of Burial: May 15 1929

20 UNDERTAKER: Stewart & Co. — ADDRESS: Balto.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Dr Mommings 323 E North Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45910

CERTIFICATE OF DEATH

129 **E 45910**

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1016 E Chase ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Catherine Dunphy

(a) RESIDENCE NO. 1016 E Chase ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Patrick Dunphy

6 DATE OF BIRTH (month, day, and year): 1871

7 AGE: Years 57 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: At home

9 BIRTHPLACE (city or town) (State or country): Md Balto

PARENTS

10 NAME OF FATHER: John Hogarty

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Elizabeth Hogarty

(Address) 1016 E Chase St

15 Filed MAY 13 1929, 19 C. HAMPSON JONES, M. D. Registrar

Per DRH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 12 1929

17 I HEREBY CERTIFY, That I attended deceased from Apr 24, 1929, to May 11, 1929, that I last saw h alive on May 11, 1929 and that death occurred, on the date stated above, at 11.30 P m.

The CAUSE OF DEATH* was as follows:

Cardiac Arrythmia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Nephritis (duration) 2 yrs. mos. ds.

(over)

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Anthony L Mommings, M. D.

5-13, 1929 (Address) 323 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross, City

DATE OF BURIAL: 5 14 1929

20 UNDERTAKER: J M Cohn

ADDRESS: 1214 E Lanvale

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45911

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

+9 E 45911

1—PLACE OF DEATH St Josephs Hospital

CITY OF BALTIMORE: (No. Caroline & Aliceanna STS 7-13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Michael Bizek

(a) RESIDENCE NO. 2005 E. Eager ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marie Bizek

6 DATE OF BIRTH (month, day, and year) Sept 24, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	67	7	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Michael Bizek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Mrs Marie Bizek

(Address) 2005 E Eager St

15 Filed MAY 19 1929 C. H. HAMPSON JONES, M. D. Registrar

By Asst

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13, 1929

17

I HEREBY CERTIFY, That I attended deceased from April 23 1929, to May 13, 1929, that I last saw him alive on May 13, 1929 and that death occurred, on the date stated above, at 8.27 A m.

The CAUSE OF DEATH* was as follows:

Sarcoma of Testicles

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Vincent Messina M. D.

, 19 (Address) St Josephs Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross

DATE OF BURIAL 5/15 1929

20 UNDERTAKER J. H. Cook

ADDRESS 127 N Eutaw St

MAY 13 1929

IMPORTANT. See instructions on back of certificates.

Spec.—2-29-28—L. P. S.—500 Blks.

E 45912

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45912

CERTIFICATE OF DEATH

90

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1107 S. Robinson ST. 1-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Wisniewska

(a) RESIDENCE NO. 1107 S. Robinson ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred [illegible] yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 5 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	4	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Michael Wisniewski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Ida Duszynski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Michael Wisniewski

(Address) 1107 S. Robinson St.

15 MAY 13 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 1929

17 I HEREBY CERTIFY, That I attended deceased from about 20 19 9 to May 11 19 29

that I last saw h alive on May 11 19 29

and that death occurred, on the date stated above, at 2.25 a.m.

The CAUSE OF DEATH* was as follows:

Chr. myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute dilatation —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) T. Joseph Conboy, M. D.

. 19 (Address) 8005 Elmwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus	May 14 1929

20 UNDERTAKER John F. Wieder

ADDRESS 4d & Chester

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E-45913

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 45913

1—PLACE OF DEATH South Baltimore General Hosp. REGISTERED NO. 2433

CITY OF BALTIMORE: (No. 1213 Light St. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lula Comuch Comicks

(a) RESIDENCE NO. 219 Hastings Way (Northway) ST., WARD Norfolk Va.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ? 1869

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
about 60 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Maid

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Henry Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Louise Dennis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Carrie B. Carrington

(Address) 730 Eagle - Norfolk Va.

15 Filed 3 1929, 19 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 5, 19 29, to May 13, 19 29, that I last saw h alive on May 13, 19 29 and that death occurred, on the date stated above, at 4-a m.

The CAUSE OF DEATH* was as follows:

Incarcerated Umbilical Hernia

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Acute Pharyngitis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? 219 Hastings Way

Did an operation precede death? Yes Date of May 5, 1929

Was there an autopsy? No

What test confirmed diagnosis? Hosp. Lab. Test

(Signed) C. W. Boynton, M. D.

, 19 (Address) 877 N. Church St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Norfolk, Va. DATE OF BURIAL 5/14/1929

20 UNDERTAKER Mrs. Geo. H. Holland ADDRESS 631 Church

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Dr Rupert 475 Park Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45914

CERTIFICATE OF DEATH

90

E 45914

REGISTERED NO. 27-56

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2138 E. Virginia ST., (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Elitha Ayers

(a) RESIDENCE NO. 2138 E Virginia Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Robert L Ayers

6 DATE OF BIRTH (month, day, and year): Jan 3. 1867

7 AGE: Years 62 | Months 4 | Days 9 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: At home

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: James Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Margaret Reynolds

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs. H. Roberts

(Address) 4737 Park Heights Ave

15 Filed MAY 14 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 12. 1929

17 I HEREBY CERTIFY, That I attended deceased from April 20, 1929, to May 12, 1929

that I last saw h[illegible] alive on May 12, 1929

and that death occurred, on the date stated above, at 9.45 A. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

2 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm A Rupert M.D.

, 19 (Address) 475 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — DATE OF BURIAL: 5 15 1929

20 UNDERTAKER: [illegible] Cook — ADDRESS: 1217 E Fayette St

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Rinzeha 800 N Gay St

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45915

CERTIFICATE OF DEATH

E 45915

1—PLACE OF DEATH

REGISTERED NO. 129

CITY OF BALTIMORE: (No. 350 N. Gay ST. 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lora Bast

(a) RESIDENCE NO. 350 N Gay ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of: William Bast

6 DATE OF BIRTH (month, day, and year): Apr 23, 1856

7 AGE — Years: 73 — Months: 0 — Days: 18 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: At home

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: John Bast

(Address): 350 N Gay St

15 Filed MAY 14 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 11 1929

17 I HEREBY CERTIFY, That I attended deceased from May 1 1929 to May 11 1929.

that I last saw h alive on May 11 1929

and that death occurred, on the date stated above, at 4 m.

The CAUSE OF DEATH* was as follows: Acute Pulmonary Mitral Regurgitation

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) J. Hall Pleasants M.D.

1929 (Address) 800 N Gay St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet

DATE OF BURIAL: May 14 1929

20 UNDERTAKER: J. W. Cook

ADDRESS: 1217 E Baltimore St

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

Lt Columbus 1901 Eaton Place

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45916

CERTIFICATE OF DEATH

90 E 45916

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 333 E. Mount ST. 14-28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Thomas Hooper

(a) RESIDENCE NO. 333 E. Mount ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillie Hooper

6 DATE OF BIRTH (month, day, and year) June 6 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	11	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Edward Hooper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary A Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Lillie Hooper

(Address) 333 E. Mount St

15 Filed MAY 14 1929 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 27, 1929, to May 13th, 1929, that I last saw him alive on May 12th, 1929, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Cardio-Renal disease

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical diagnosis

(Signed) H. B. Silverhouse M. D.

5/13, 1929 (Address) 1901 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	5/16 19 29
B. UNDERTAKER J. M. Cook	ADDRESS 1217 E. Fayette St

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—800 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45917

CERTIFICATE OF DEATH

74-001

E 45917

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 624 N. Sterling ST., 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Gertrude Handley

(a) RESIDENCE NO. 624 N. Sterling ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) — — 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
46	45	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Emma Boyd

(Address) 624 N. Sterling

15 Filed ....., 19.... HARRISON JONES, M. D. 14.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12. 29

17 I HEREBY CERTIFY, That I attended deceased from May 11, 19 29, to May 12, 19 29, that I last saw h e alive on May 12, 19 29 and that death occurred, on the date stated above, at 4:10 P.m.

The CAUSE OF DEATH* was as follows:

Acute Hypertension

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exa

(Signed) W. L. Berry, M. D.

19 (Address) 1420 E. Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary Cem — DATE OF BURIAL May 15 1929

20 UNDERTAKER Robert W. Williams — ADDRESS 515 McCulloh St

IMPORTANT. See instructions on back of certificates.

MAY 14 1929

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45918

CERTIFICATE OF DEATH

3 | E 45918

1—PLACE OF DEATH

REGISTERED NO. 6-9

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST., C.T.B. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Irene Harris

(a) RESIDENCE NO. 1645 E. Fayette st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Harris

6 DATE OF BIRTH (month, day, and year) 1906

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER August Pembert

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Elizabeth Woodson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant Hospital Records

(Address)

15 Filed MAY 14 1929, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 10, 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec. 26, 1928, to May 10, 1929, that I last saw her alive on May 10, 1929 and that death occurred, on the date stated above, at 12 n. m.

The CAUSE OF DEATH* was as follows:

Caseous Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Hampson Jones M. D.

5-10, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Calvary Cemetery	May 14 1929
UNDERTAKER	ADDRESS
Robert J. Miller	1515 Mc Elroy st

IMPORTANT—Fill in plain terms, so that it may be easily read. Every item important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

45919

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

185 E 45919

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Hopkins Hospital St., 7-4 Ward)

2-FULL NAME Rossie Brown

(a) RESIDENCE NO. 1623 E. Monument St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F	Black	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 8/27

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	2	0	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town)
(State or country) N.C.

10 NAME OF FATHER Alexander Brown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) N.C.

12 MAIDEN NAME OF MOTHER Lizzie See

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) N.C.

14 Informant Alexander Brown
(Address) 1623 E. Monument St

15 Filed ..., 19... HAMILTON O. JONES, M. D.
Registrar

MAY 14 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11/29

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probable Concussion Brain

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Accidently fell out of bed at home (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of May 11/29

Was there an autopsy? yes at Hopkins

What test confirmed diagnosis?

(Signed) H. B. Cotton, M. D.

5/13-1929 (Address) 708 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	May 14 1929
20 UNDERTAKER	ADDRESS
Robert H. Williams	1515 Pennsylvania Ave

Note—Physicians, Undertakers and Informants: Every question should be carefully answered. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 45920

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

167-001

E 45920

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Agnes Hosp. St. 30-69 Ward)

2-FULL NAME Charles E. Carey

(a) RESIDENCE NO. 2512 Eutaw Pl. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	W. hite	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Tillie D. Flynn

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	37	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Brakeman
(b) General nature of industry, business, or establishment in which employed (or employer) B & O. R.R. Co
(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Edward Carey

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Tillie E. Carey
(Address) 850 W. Fayette

15 Filed MAY 14 1929 C. HAMPSON JONES, M. D. Registrar
by Lott

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Suicide - by Illuminating Gas.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. H. Smoke, M. D.

5/11, 1929 (Address) 3601 3rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem.	May 14 1929
20 UNDERTAKER	ADDRESS
George J. Rutt	1735 Harford Av

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 45921 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001

E 45921

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 402 N. Fremont Ave. St.) (18-16 WARD)

2—FULL NAME: James Edw. Monroe

(a) RESIDENCE NO. 402 N Fremont Ave (Usual place of abode)

WARD

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs Matilda Monroe

6 DATE OF BIRTH (month, day, and year): Jan 12 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	3	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Driver

(b) General nature of industry, business, or establishment in which employed (or employer): Meat Packing

(c) Name of employer: Swift & Co

9 BIRTHPLACE (city or town) (State or country): Hagerstown, Md

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not Known

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant: Mrs Matilda Monroe

(Address) 402 N. Fremont

15 Filed MAY 14 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 11- 1929

17 I HEREBY CERTIFY, That I attended deceased from Apr 27 1929 to May 11th 1929, that I last saw him alive on May 11th 1929, and that death occurred, on the date stated above, at 8.55 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (Bilateral)

CONTRIBUTORY (Secondary) (duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Diagnosis

(Signed) Jas. E. Lee, M. D.

, 19 (Address) 1 E Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Ct

DATE OF BURIAL: May 15 1929

20 UNDERTAKER: J. H. Brown & Son

ADDRESS: 1811 Madison

MAY 14 1929

IMPORTANT. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

129 ✓

CERTIFICATE OF DEATH.

E 45922

REGISTERED NO. E 45922

1-PLACE OF DEATH

City of BALTIMORE: (No. 17 N. Churchill St. 27-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jagnora Bailey

(a) RESIDENCE NO. 17 N. Churchill St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. 5 mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): April 18 1911

7 AGE: Years 17 Months — Days 13 IF LESS than 1 day.....hrs. or.....min. 24

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Henry Bailey

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER L. Davis

13 BIRTHPLACE OF MOTHER (city or town): Baltimore

(State or country)

14 Informant: Jacob L. Bailey

(Address) 17 N. Churchill St

Filed MAY 14 1929 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 12 1929

17 I HEREBY CERTIFY, That I attended deceased from April 14 1929, to May 12 1929, that I last saw her alive on May 8 1929, and that death occurred, on the date stated above, at 7:00 a.m.

The CAUSE OF DEATH* was as follows: Acute Dilation of Heart 4 Months Duration

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Oedema of whole body (duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C. Edw. Burgess, M. D.

May 13, 1929 (Address) 710 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Zion Ct Date of Burial May 15 1929

20 UNDERTAKER: N. R. Brown & Son ADDRESS 1051 Hanover

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

45923

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 ✓

E 45923

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Balto. City Hospitals St., 7th Ward)

2-FULL NAME Samuel Lowry

(a) RESIDENCE NO. 409 E Cross St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 14 1883

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	46	2	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Common
(c) Name of employer

9 BIRTHPLACE (city or town) Balto City
(State or country)

PARENTS

10 NAME OF FATHER Wm Lowry

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto City

12 MAIDEN NAME OF MOTHER Eleanora Bonner

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto City

14 Informant James S Marshall
(Address) Boiler on College

15 Filed MAY 14 1929 19 WILLIAMS S. JONES, M. D. Registrar
By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) months yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? 409 E Cross

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Thomas Pullen, M. D.

5/13 1929 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	May 14th 1929
20 UNDERTAKER	ADDRESS
Leo G. Cook	1923 Pat Pk Ave

N. B.—WRITE PLAINLY with pen and ink. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45924

CERTIFICATE OF DEATH.

16-01 14727

16-01 45924

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2335 Lauretta Ave. 70-64 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dufant Ludwig

(a) RESIDENCE NO. 2335 Lauretta Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	W.	Sing

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 11, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
				14

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... Infant. ditto

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER W. T. Ludwig

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER M. V. Stenner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant W. T. Ludwig

(Address) 2335 Lauretta Ave

MAY 14 1929

MAY 12 19 29 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11 19 29

17 I HEREBY CERTIFY, That I attended deceased from ....., 19...., to ....., 19....,

that I last saw h alive on ....., 19....

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Premature Birth

6 mo.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Wilson Ross, M. D.

5/11 19 29 Address) 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
	, 19
20 UNDERTAKER	ADDRESS

UNIVERSITY OF MARYLAND

Commissioner Health.

MAY 1 1929

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Brown

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45925

CERTIFICATE OF DEATH.

1-02

10 E 45925

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital St., 5-4 WARD)

2-FULL NAME Rae Brown

(a) RESIDENCE NO. 1736 N. Eutaw St. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? 9 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced. (write the word): married

5a If married, widowed, or divorced. HUSBAND of (or) WIFE of: Abraham Brown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: 41 — Months: — — Days: — — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Abraham Rabanow

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Jack Lewis

(Address) 1439 E. Baltimore St.

15 Filed MAY 14 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 13 1929

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1929, to May 12, 1929,

that I last saw h[illegible] alive on May 12, 1929,

and that death occurred, on the date stated above, at 5:00 A m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 13, 1929

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) Fredrick D Wolf M. D.

5-13 1929 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bals Hebrew Cem — DATE OF BURIAL: 5/14 1929

20 UNDERTAKER: Jack Lewis — ADDRESS: 1439 E Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. Information CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 45926 HEALTH DEPARTMENT—CITY OF BALTIMORE E 45926

CERTIFICATE OF DEATH.

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1238 Mc Elderry ST., 5-8 (WARD)

2-FULL NAME Mary Simon

(a) RESIDENCE NO. 1238 Mc Elderry ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Fannie Simon

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 57 | Months — | Days — | If LESS than 1 day, ...hrs or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Real Estate

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Fannie Simon
(Address): 1238 Lewis

15 Filed ....., 19.... HAMILTON JONES, M. D.
Registrar

MAY 14 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5-13-1929

17 I HEREBY CERTIFY, That I attended deceased from 3-30, 1929, to May 13, 1929, that I last saw him alive on May 13, 1929, and that death occurred, on the date stated above, at 9.30 m.

The CAUSE OF DEATH* was as follows:

Ch Nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. L. Hamilton, M. D.

5/13, 1929 (Address) 733 Augusta St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Hebrew Rest — DATE OF BURIAL: 5/14 1929

20 UNDERTAKER: Jacob Lewis ADDRESS: 1439 E Baltimore St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45927

CERTIFICATE OF DEATH

E 45927

1-PLACE OF DEATH Maryland General Hosp. REGISTERED NO. 24-35

City of BALTIMORE: (No. Howard + Madison St.) (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Stanofsky

(a) RESIDENCE NO. 1400 Hunbert St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred [illegible] mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 2-1921

7 AGE: 7 Years 8 Months 10 Days 11

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Maryland

PARENTS

10 NAME OF FATHER Peter Stanofsky

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Austria Hungary

12 MAIDEN NAME OF MOTHER Elizabeth Wiener

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Austria Hungary

14 Informant Hosp Record

(Address)

15 Filed 19 [illegible] Registrar

C. HARRISON JONES, M. D.

DEPUTY

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 13 1929

17 I HEREBY CERTIFY, That I attended deceased from May 5, 1929 to May 13, 1929, that I last saw h[illegible] alive on May 13, 1929, and that death occurred, on the date stated above, at 5 30 A. m.

The CAUSE OF DEATH* was as follows:

Acute Purulent Appendicitis

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 6, 1929

Was there an autopsy? No

What test confirmed diagnosis? Operation + Clinical

(Signed) H. E. Kerfoot Meeder, M. D.

5/13, 1929 (Address) Md. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross, Md. Co.

Date of Burial: May 15 1929

20 UNDERTAKER: Chas. L. Stevens

ADDRESS 1307 E Fort Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

NOV 14 1929

Spec.—2-29-28—L. F. S.—500 Bks.

E 45926

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45728

CERTIFICATE OF DEATH

31

1—PLACE OF DEATH

REGISTERED NO. 17-25

CITY OF BALTIMORE: (No. 1209 Upton ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Irene Finney - Waddell Coleman

(a) RESIDENCE NO. 1209 Upton ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Coleman

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment, in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Thomas Cuttler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Lila [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant King [illegible]

(Address) 1209 Upton St

15 Filed MAY 14 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12th. 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 2 1929, to May 11, 1929

that I last saw h[illegible] alive on May 4, 1929

and that death occurred, on the date stated above, at 7:30 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

a Both. Lungs.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Rheumatism

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thomas H. Maynes M. D.

5/13, 1929 (Address) 14 E. [illegible] St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkdale Va. DATE OF BURIAL 5-15 1929

20 UNDERTAKER Daniel Carter ADDRESS 916 Druid

OF DEATH in plain terms, so that it may be properly classified. Every item important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45929 45 E 45929

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 1024

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 921 N. Calvert ST., (WARD)

2—FULL NAME Thomas Humes Musgrave

(a) RESIDENCE NO. 921 N. Calvert ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. 9 mos. 25 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 17. 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	78	9	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired. 045

(b) General nature of industry, business, or establishment in which employed (or employer) Retired Business

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER James Musgrave

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Ellen Humes

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant Walter Musgrave

(Address) 921 N Calvert St

15 Filed MAY 14 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12th 1929

17 I HEREBY CERTIFY, That I attended deceased from May 1st 1929, to May 12th 1929 that I last saw h alive on May 12th 1929 and that death occurred, on the date stated above, at 7.45 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum
Cachexia
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) None
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? V

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? V

(Signed) Stephens Bunch M. D.

5/13. 1929 (Address) 210 S. Chas St

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cem	May 14th 1929
20 UNDERTAKER	ADDRESS
Henry H. Jenkins Sons	McCulloh + Orchard.

OF DEATH in plain terms, so that it may be properly classified. Fill in all items. Typewriter is preferred. Use black ink if typewriter is not available. Be sure your answers are important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45930

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45930

CERTIFICATE OF DEATH

124

1—PLACE OF DEATH

REGISTERED NO. 1-24

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1224 Madison Ave ST., 41-24 WARD)

2—FULL NAME Isaac S Norris

(a) RESIDENCE NO. 1224 Madison ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1842 March 14

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	87	1	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Banker 045

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Savings Bank of Balto.

9 BIRTHPLACE (city or town) Harford Co. "Olney"

(State or country) Maryland

PARENTS

10 NAME OF FATHER John Saurin Norris

11 BIRTHPLACE OF FATHER (city or town) Balto

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Henrietta Upton

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Md.

14 Informant Henrietta P. Goodridge Sister

(Address) 34 E. 63rd St. City

15 Filed MAY 14 1929 H. HARRY JONES, M. Registrar

by [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13/29

17 I HEREBY CERTIFY, That I attended deceased from April, 1923, to May 12, 1929.

That I last saw him alive on May 12, 1929

and that death occurred, on the date stated above, at 6a m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Neil S. Hecht M. D.

5/13, 1929 (Address) 1403 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL May 15 1929

UNDERTAKER Henry H. Tuckers Son — ADDRESS McCulloh & Eutaw Sts

IMPORTANT—FILL IN ALL BLANKS IF INFORMATION IS OBTAINABLE. WRITE PLAINLY. USE INK. DEATH CERTIFICATE MUST BE FILED WITH REGISTRAR OF VITAL STATISTICS BEFORE BODY IS REMOVED FROM STATE. STATE LAW REQUIRES THAT A PERMIT FOR BURIAL, REMOVAL OR CREMATION BE OBTAINED FROM THE REGISTRAR BEFORE ANY BODY IS BURIED, REMOVED OR CREMATED. DEATH CERTIFICATE MUST BE FILED WITHIN FIVE DAYS AFTER DEATH. DEATH OCCURRING WITHOUT MEDICAL ATTENDANCE MUST BE REPORTED TO THE CORONER. DEATH OCCURRING IN A HOSPITAL MUST BE REPORTED BY THE SUPERINTENDENT OR HIS DESIGNATED AGENT. DEATH OCCURRING IN A PUBLIC PLACE MUST BE REPORTED TO THE POLICE. DEATH OCCURRING ON A VESSEL MUST BE REPORTED TO THE MASTER. DEATH OCCURRING ON A TRAIN MUST BE REPORTED TO THE CONDUCTOR. DEATH OCCURRING IN AN AUTOMOBILE MUST BE REPORTED TO THE DRIVER. DEATH OCCURRING IN AN AIRPLANE MUST BE REPORTED TO THE PILOT. DEATH OCCURRING IN A PRISON MUST BE REPORTED TO THE WARDEN. DEATH OCCURRING IN A CEMETERY MUST BE REPORTED TO THE SEXTON. DEATH OCCURRING IN A CREMATORY MUST BE REPORTED TO THE CREMATORY OPERATOR. DEATH OCCURRING IN A MORTUARY MUST BE REPORTED TO THE MORTUARY OPERATOR. DEATH OCCURRING IN A HOTEL MUST BE REPORTED TO THE MANAGER. DEATH OCCURRING IN A RESTAURANT MUST BE REPORTED TO THE MANAGER. DEATH OCCURRING IN A THEATRE MUST BE REPORTED TO THE MANAGER. DEATH OCCURRING IN A CHURCH MUST BE REPORTED TO THE PASTOR. DEATH OCCURRING IN A SCHOOL MUST BE REPORTED TO THE PRINCIPAL. DEATH OCCURRING IN A FACTORY MUST BE REPORTED TO THE MANAGER. DEATH OCCURRING IN A MINE MUST BE REPORTED TO THE MANAGER. DEATH OCCURRING IN A QUARRY MUST BE REPORTED TO THE MANAGER. DEATH OCCURRING IN A FARM MUST BE REPORTED TO THE FARMER. DEATH OCCURRING IN A RANCH MUST BE REPORTED TO THE RANCHER. DEATH OCCURRING IN A LOGGING CAMP MUST BE REPORTED TO THE FOREMAN. DEATH OCCURRING IN A CONSTRUCTION CAMP MUST BE REPORTED TO THE FOREMAN. DEATH OCCURRING IN A MILITARY CAMP MUST BE REPORTED TO THE COMMANDING OFFICER. DEATH OCCURRING IN A NAVAL VESSEL MUST BE REPORTED TO THE COMMANDING OFFICER. DEATH OCCURRING IN A MERCHANT VESSEL MUST BE REPORTED TO THE MASTER. DEATH OCCURRING IN A FISHING VESSEL MUST BE REPORTED TO THE MASTER. DEATH OCCURRING IN A PLEASURE VESSEL MUST BE REPORTED TO THE MASTER. DEATH OCCURRING IN A SAILING VESSEL MUST BE REPORTED TO THE MASTER. DEATH OCCURRING IN A STEAMSHIP MUST BE REPORTED TO THE MASTER. DEATH OCCURRING IN A TUGBOAT MUST BE REPORTED TO THE MASTER. DEATH OCCURRING IN A BARGE MUST BE REPORTED TO THE MASTER. DEATH OCCURRING IN A DREDGE MUST BE REPORTED TO THE MASTER. DEATH OCCURRING IN A FERRY MUST BE REPORTED TO THE MASTER. DEATH OCCURRING IN A LIGHTHOUSE MUST BE REPORTED TO THE KEEPER. DEATH OCCURRING IN A LIFESAVING STATION MUST BE REPORTED TO THE KEEPER. DEATH OCCURRING IN A COAST GUARD STATION MUST BE REPORTED TO THE COMMANDING OFFICER. DEATH OCCURRING IN A NAVAL HOSPITAL MUST BE REPORTED TO THE COMMANDING OFFICER. DEATH OCCURRING IN A MARINE HOSPITAL MUST BE REPORTED TO THE COMMANDING OFFICER. DEATH OCCURRING IN A PUBLIC HOSPITAL MUST BE REPORTED TO THE SUPERINTENDENT. DEATH OCCURRING IN A PRIVATE HOSPITAL MUST BE REPORTED TO THE SUPERINTENDENT. DEATH OCCURRING IN A NURSING HOME MUST BE REPORTED TO THE MANAGER. DEATH OCCURRING IN A BOARDING HOUSE MUST BE REPORTED TO THE MANAGER. DEATH OCCURRING IN A LODGING HOUSE MUST BE REPORTED TO THE MANAGER. DEATH OCCURRING IN A TENEMENT MUST BE REPORTED TO THE MANAGER. DEATH OCCURRING IN A FLAT MUST BE REPORTED TO THE MANAGER. DEATH OCCURRING IN A PRIVATE RESIDENCE MUST BE REPORTED TO THE HEAD OF THE FAMILY. DEATH OCCURRING IN A PUBLIC PLACE MUST BE REPORTED TO THE POLICE. DEATH OCCURRING ON A VESSEL MUST BE REPORTED TO THE MASTER. DEATH OCCURRING ON A TRAIN MUST BE REPORTED TO THE CONDUCTOR. DEATH OCCURRING IN AN AUTOMOBILE MUST BE REPORTED TO THE DRIVER. DEATH OCCURRING IN AN AIRPLANE MUST BE REPORTED TO THE PILOT. DEATH OCCURRING IN A PRISON MUST BE REPORTED TO THE WARDEN. DEATH OCCURRING IN A CEMETERY MUST BE REPORTED TO THE SEXTON. DEATH OCCURRING IN A CREMATORY MUST BE REPORTED TO THE CREMATORY OPERATOR. DEATH OCCURRING IN A MORTUARY MUST BE REPORTED TO THE MORTUARY OPERATOR. DEATH OCCURRING IN A HOTEL MUST BE REPORTED TO THE MANAGER. DEATH OCCURRING IN A RESTAURANT MUST BE REPORTED TO THE MANAGER. DEATH OCCURRING IN A THEATRE MUST BE REPORTED TO THE MANAGER. DEATH OCCURRING IN A CHURCH MUST BE REPORTED TO THE PASTOR. DEATH OCCURRING IN A SCHOOL MUST BE REPORTED TO THE PRINCIPAL. DEATH OCCURRING IN A FACTORY MUST BE REPORTED TO THE MANAGER. DEATH OCCURRING IN A MINE MUST BE REPORTED TO THE MANAGER. DEATH OCCURRING IN A QUARRY MUST BE REPORTED TO THE MANAGER. DEATH OCCURRING IN A FARM MUST BE REPORTED TO THE FARMER. DEATH OCCURRING IN A RANCH MUST BE REPORTED TO THE RANCHER. DEATH OCCURRING IN A LOGGING CAMP MUST BE REPORTED TO THE FOREMAN. DEATH OCCURRING IN A CONSTRUCTION CAMP MUST BE REPORTED TO THE FOREMAN. DEATH OCCURRING IN A MILITARY CAMP MUST BE REPORTED TO THE COMMANDING OFFICER. DEATH OCCURRING IN A NAVAL VESSEL MUST BE REPORTED TO THE COMMANDING OFFICER. DEATH OCCURRING IN A MERCHANT VESSEL MUST BE REPORTED TO THE MASTER. DEATH OCCURRING IN A FISHING VESSEL MUST BE REPORTED TO THE MASTER. DEATH OCCURRING IN A PLEASURE VESSEL MUST BE REPORTED TO THE MASTER. DEATH OCCURRING IN A SAILING VESSEL MUST BE REPORTED TO THE MASTER. DEATH OCCURRING IN A STEAMSHIP MUST BE REPORTED TO THE MASTER. DEATH OCCURRING IN A TUGBOAT MUST BE REPORTED TO THE MASTER. DEATH OCCURRING IN A BARGE MUST BE REPORTED TO THE MASTER. DEATH OCCURRING IN A DREDGE MUST BE REPORTED TO THE MASTER. DEATH OCCURRING IN A FERRY MUST BE REPORTED TO THE MASTER. DEATH OCCURRING IN A LIGHTHOUSE MUST BE REPORTED TO THE KEEPER. DEATH OCCURRING IN A LIFESAVING STATION MUST BE REPORTED TO THE KEEPER. DEATH OCCURRING IN A COAST GUARD STATION MUST BE REPORTED TO THE COMMANDING OFFICER. DEATH OCCURRING IN A NAVAL HOSPITAL MUST BE REPORTED TO THE COMMANDING OFFICER. DEATH OCCURRING IN A MARINE HOSPITAL MUST BE REPORTED TO THE COMMANDING OFFICER. DEATH OCCURRING IN A PUBLIC HOSPITAL MUST BE REPORTED TO THE SUPERINTENDENT. DEATH OCCURRING IN A PRIVATE HOSPITAL MUST BE REPORTED TO THE SUPERINTENDENT. DEATH OCCURRING IN A NURSING HOME MUST BE REPORTED TO THE MANAGER. DEATH OCCURRING IN A BOARDING HOUSE MUST BE REPORTED TO THE MANAGER. DEATH OCCURRING IN A LODGING HOUSE MUST BE REPORTED TO THE MANAGER. DEATH OCCURRING IN A TENEMENT MUST BE REPORTED TO THE MANAGER. DEATH OCCURRING IN A FLAT MUST BE REPORTED TO THE MANAGER. DEATH OCCURRING IN A PRIVATE RESIDENCE MUST BE REPORTED TO THE HEAD OF THE FAMILY.

OF DEATH in plain terms, so that it may be properly classified. Take particular care to be important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45931

CERTIFICATE OF DEATH

E 45931

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 812 Carline St., 22-31 Ward)

2-FULL NAME Robt M. Pennington

(a) RESIDENCE NO. 17 W. West St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred ~~yrs.~~ ~~mos.~~ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male | 4 Color or Race: White | 5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs Cora Pennington

6 DATE OF BIRTH (month, day, and year): Dec 30th 1861

7 AGE: Years 67 | Months 4 | Days 12 | IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Watchman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

062

9 BIRTHPLACE (city or town): New Jersey
(State or country)

PARENTS

10 NAME OF FATHER: Nathan Pennington

11 BIRTHPLACE OF FATHER (city or town): N. J.
(State or country)

12 MAIDEN NAME OF MOTHER: Mc Coy

13 BIRTHPLACE OF MOTHER (city or town): N. J.
(State or country)

14 Informant: Mrs. Cora Pennington
(Address) 17 W. West St.

15 Filed ....., 19.... C. HAMPSON JONES, M. D. Registrar.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 12 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to h[illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? History

(Signed) J. C. Blades M. D.

19 (Address) 143 N. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Hill Cemetery	May 15 1929
20 UNDERTAKER: George L. Schwartz & Bro. Inc.	ADDRESS

NOTE—WRITE PLAINLY, WITH INK. Information should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAY 14 1929

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45932

CERTIFICATE OF DEATH

101-001

E 45932

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 707 N. Collington Ave ST., 12 WARD)

2—FULL NAME Mencestaus L. Shimels

(a) RESIDENCE NO. 707 N. Collington Ave ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Frances Shimels

6 DATE OF BIRTH (month, day, and year) Aug 4 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	9	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cable Inspector

(b) General nature of industry, business, or establishment in which employed (or employer) City Elect. Serv

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Vincent Shimels

11 BIRTHPLACE OF FATHER (city or town) (State or country) Sicily

12 MAIDEN NAME OF MOTHER Mary Forst

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Sicily

14 Informant Frances Shimels

(Address) 707 N Collington Ave

15 Filed C. HAMPSON JONES, M. D. Registrar

MAY 14 1928

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2, 1928

17 I HEREBY CERTIFY, That I attended deceased from 5-4-28 to 5-12-28

that I last saw h alive on 5-12-28

and that death occurred on the date stated above, at 11:30 P. M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Acute Myocarditis 3 days

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Residence

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Bernard Brosius M. D.

PD 24 1928 (Address) 600 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL May 1928

20 UNDERTAKER Wm Crouch Son

ADDRESS Eutaw and Fa

OF DEATH in plain terms, so that it may be properly classified. State whether a woman was married, single, widow or divorced. Name of husband or wife should be given in full. Occupation should be stated for every person, whether actively employed or not. Write plainly with pen and ink and use no abbreviations. The space for cause of death should be filled with the primary cause, secondary or contributory causes, and complications. Indefinite and unsatisfactory terms, such as "Heart Failure," "Asthenia," "Senility," "Old Age," "Cancer," "Tumor," should be avoided. Causes of death which may be the result of occupation should be reported. Deaths from any form of violence must be fully reported, stating the means of injury and whether accidental, suicidal or homicidal. Physicians are required to report to the Registrar deaths of persons not attended during last illness, stating time and place of last attendance. Midwives are required to report stillbirths. Burial or removal permit must be obtained before interment or removal from city. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45933

CERTIFICATE OF DEATH

11-001

E 45933

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 209 S. Bethel ST., 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alice Bedford

(a) RESIDENCE NO. 209 S. Bethel ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: C.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): [illegible] 1896

7 AGE: Years 33 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: John H. Bedford

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Mary E. Hicks

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

Informant: John H. Bedford

(Address) 209 S. Bethel St.

15 Filed [illegible], 19[illegible]

C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 10, 1929

17

I HEREBY CERTIFY, That I attended deceased from May 6, 1929, to May 10, 1929,

that I last saw her alive on May 9, 1929

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Influenza

Bronchio-Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Bernard Harris, M. D.

5/14, 1929 (Address) 38 S Carlin St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Westminster Cemetery — DATE OF BURIAL: May 14 1929

20 UNDERTAKER: Wm. R. A. Elliott — ADDRESS: 17 Ashland Ave

MAY 14 1929

OF DEATH in plain terms, so that it may be properly classified. Every question must be answered. Write plainly with pen and ink. Use only standard abbreviations. Do not use ditto marks. Be particularly careful to make all figures clear. Every item is important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45934
1-PLACE OF DEATH

CERTIFICATE OF DEATH

180-001

E 45934
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of Baltimore: (No. 330 N. Strieker St., 14-27 Ward)

2-FULL NAME Russell Taylor

(a) RESIDENCE NO. 330 N Strieker St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) January 16, 1929

7 AGE	Years	Months 3 4	Days 27	IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER Russell Taylor

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto Md

12 MAIDEN NAME OF MOTHER Helen Murray

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto Md

14 Informant Helen Murray
(Address) 330 N Strieker

15 Filed 19 HAMILTON JONES, M. D.
Registrar

MAY 14 1929 1001

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to L. death on the day stated above.
The CAUSE OF DEATH* was as follows:
Suffocation. (Accd)

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. H. Brooke M. D.

May 14 1929 (Address) 3601 3rd Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	May 16 1929
20 UNDERTAKER	ADDRESS
Mrs. Kate R. Williams	327 N. Schroeder St

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45935

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

E 45935

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 904 Russell ST. 21-31 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles M Hayes

(a) RESIDENCE NO. 904 Russell ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eliza Hayes

6 DATE OF BIRTH (month, day, and year) Nov. 22, 1871

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
5 8	1	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lynchburg Va

PARENTS

10 NAME OF FATHER Charles Hayes

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Lucy ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Eliza A. Hayes

(Address) 904 Russell St

Filed MAY 14 1929, 19 H. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11/29

17 I HEREBY CERTIFY, That I attended deceased from May 6, 1929 to May 11, 1929 that I last saw him alive on May 11, 1929 and that death occurred, on the date stated above, at 1150 P m.

The CAUSE OF DEATH* was as follows:

Cardio-renal disease

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptomatic

(Signed) J. S. McCard M. D.

5/13 1929 (Address) 2005 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL May 14, 1929

20 UNDERTAKER Wm. & Katie R. Williams — ADDRESS 322 N Schroeder St

OF DEATH in plain terms, so that it may be properly classified. important. See instructions on back of certificates.

MAY 14 1929

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45936

CERTIFICATE OF DEATH.

46 E 45936

1-PLACE OF DEATH

City of BALTIMORE: (No. 2117 Huntington Ave. 7-51 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Klitch

(a) RESIDENCE NO. 2117 Huntington Ave. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): April 17 78

7 AGE: Years 51 | Months — | Days 25 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Henry Klitch

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Charlotta Heise

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Richard Klitch

(Address) 2117 Huntington ave

MAY 14 1929

C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12th 1929

17 I HEREBY CERTIFY, That I attended deceased from May 1st 1929 to May 12th 1929, that I last saw h.. alive on May 12th 1929, and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma, Uterine

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Geo. McCross, M. D.

. 19 (Address) 78 W 25th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Mem. Date of Burial 5/14 1929

20 UNDERTAKER: Liston F. Fussell & Son ADDRESS 2620 St Paul

IMPORTANT.—WRITE PLAINLY, WITH LEAD PENCIL. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate. 14

Spec.—2-29-28—L. F. S.—500 Bks.

E 45937

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001

E 45937

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Balt. City Hosp. ST., 1-3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Geo. Patro

(a) RESIDENCE NO 816 S. Luzerne ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frances Patro

6 DATE OF BIRTH (month, day, and year) Mar. 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41	2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) U. S.

PARENTS

10 NAME OF FATHER Geo Patro

11 BIRTHPLACE OF FATHER (city or town) (State or country) Europe

12 MAIDEN NAME OF MOTHER Jennie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Europe

14 Informant Frances Patro

(Address) 816 S. Luzerne ave

15 Filed 1 C. HAMPSON JONES, Registrar

141929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/13/29

17 I HEREBY CERTIFY, That I attended deceased from 4/20, 1929, to 5/13, 1929, that I last saw h/z alive on 5/13, 1929 and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Empyema right chest

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Lola Lampkin, M. D.

5/13, 1929 (Address) Balt City Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem	May 6 1929
20 UNDERTAKER	ADDRESS
Stephen L. Fiaffenbino Inc	1000 S. Kenwood Ave

OF DEATH in plain terms, so that it may be properly classified. Each statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

9 Illar

E 45938

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X101-001

E 45938

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hosp (or) (WARD) 14-20

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Matilda Illar

(a) RESIDENCE NO. Orringes Mills ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lewis Illar

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt. County.

PARENTS

10 NAME OF FATHER Lewis Illar

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt. County

12 MAIDEN NAME OF MOTHER Mary Norris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt. County

14 Informant Mother (Address)

15 Filed MAY 14 1928 HAMPSON JONES, M. D. Registrar

Recorded by

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/11/1929

17 I HEREBY CERTIFY, That I attended deceased from 5-8, 1929, to 5-11, 1929, that I last saw h[illegible] alive on May 11, 1929, and that death occurred, on the date stated above, at 3:10 A m.

The CAUSE OF DEATH* was as follows: Meningitis (Pneumococcic following Lobar Pneumonia)

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Undetermined

Did an operation precede death? no Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) H. L. Jackson, M. D.

5/14/1929 (Address) 600 N Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudis Chapel

DATE OF BURIAL 5/14/1929

20 UNDERTAKER Geo. H. Kolla

ADDRESS 1631 Druid Hill

INSTRUCTIONS TO PHYSICIANS: Physicians are urgently requested to fill out this certificate promptly. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 45939 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 45939

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 517 W. Biddle ST., 7-24 (WARD)

2-FULL NAME Lamie Wicks

(a) RESIDENCE No. 517 W. Biddle ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: X

6 DATE OF BIRTH (month, day, and year): 1849

7 AGE: Years 80? Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: James Hawkins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant (Address): Mrs Parker Balto City

15 Filed MAY 14 1929 By C. HAMILTON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 12 1929

17 I HEREBY CERTIFY, That I attended deceased from May 9th, 1929, to May 12th, 1929, that I last saw her alive on May 11, 1929, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease about

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Chronic Bright's about

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Samuel A Bann M. D.

, 19 (Address) 937 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem

DATE OF BURIAL: May 14, 29

20 UNDERTAKER: Samuel T. Newsley

ADDRESS: 517 W Biddle

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45940

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of Baltimore: (No. City Hospital St. 26-37 Ward)

2-FULL NAME Wm H Earback

(a) RESIDENCE NO. 3436 Leverton St., 26 Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

E 45940

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary Earback.

6 DATE OF BIRTH (month, day, and year) Mch 12th 1870

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
59	2		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Watchman for Ice
(b) General nature of industry, business, or establishment in which employed (or employer) Canton Co. 062
(c) Name of employer

9 BIRTHPLACE (city or town) Balto Co
(State or country) Md.

PARENTS

10 NAME OF FATHER John J. Earback

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Georgianna York

13 BIRTHPLACE OF MOTHER (city or town) Balto Co
(State or country)

14 Informant Mary Earback Wife
(Address) 3436 Leverton ave

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D., Registrar
By .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 2 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows: Arter Occ Multiple Fractures
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Shock
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Eastern & Clinton Sts

Did an operation precede death? — Date of —
Was there an autopsy? Yes
What test confirmed diagnosis? Exam
(Signed) C. E. Gladden, M. D.
, 19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	May 15 1929
20 UNDERTAKER Lilly & Zeiler Inc.	ADDRESS 1025 W Fayette St.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAY 14 1929

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45941

CERTIFICATE OF DEATH

38 E 45941

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 19-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Henderson

(a) RESIDENCE NO. 508 Bruce ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Charles Henderson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Lettie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Records of

(Address) Baltimore City Hospitals

15 Filed MAY 14 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 9, 1929

17 I HEREBY CERTIFY, That I attended deceased from January 23, 1929, to May 9, 1929, that I last saw him alive on May 9, 1929 and that death occurred, on the date stated above, at 11 P m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

Chronic myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Aneurysm of Descending Arch: Syphilis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harvey W. McLean, M. D.

19 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS Commissioner Health. MAY 14 1929

MAY 14 1929

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45942

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 45942

1—PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO.

CITY OF BALTIMORE: (No. 18-N ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Beckett

(a) RESIDENCE NO. 837 W. Fairmount Ave. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Beckett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Susan ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records of
(Address) Baltimore City Hospitals

15 Filed MAY 14 1929 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 9, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 2, 1929 to May 9, 1929, that I last saw him alive on May 9, 1929 and that death occurred, on the date stated above, at 6 A. M.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis
Auricular fibrillation
Myocardial insufficiency

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis
Emphysema (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam.

(Signed) Wilbur A. McClain, M. D.

19 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health

ADDRESS MAY 14 1929

Per Wm. E. WOODALL

Spec.—7-17-26—A Co.—200 Bks.

E 45943

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001

E 45943

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1001 St. Paul St. 11-15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mark Curry

(a) RESIDENCE NO. 1001 St. Paul St.

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds.

St. Ward

(If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (Husband of (or) Wife of): Mary M. Curry

6 DATE OF BIRTH (month, day, and year): June 25 1890

7 AGE — Years: 39 Months: 3 Days: 17

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Druggist

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Wyatte. Florida

PARENTS

10 NAME OF FATHER: Wesley B Curry

11 BIRTHPLACE OF FATHER (City or town) (State or country): Ky Mich Florida

12 MAIDEN NAME OF MOTHER: Mary H. Wyatt

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Florida

14 Informant (Address): Mary M Curry Bradenton Florida

15 Filed MAY 14 1929

C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 14th 1929

17

I HEREBY CERTIFY, That I attended deceased from May 7th, 1929, to May 14th, 1929, that I last saw him alive on May 14th, 1929, and that death occurred, on the date stated above, at 3 30 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Examination.

(Signed) H Calvert Hall M. D.

May 14th, 1929. (Address) 3006 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bradenton Fla. Date of Burial 5/14 1929

20 UNDERTAKER: Chas R. Crawford Low ADDRESS: 118 W Mt Royal Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—This is a permanent record. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45944

HEALTH DEPARTMENT—CITY OF BALTIMORE

60-001

E 45944

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 639 S. New Kirk ST., 16-37 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Breeden

(a) RESIDENCE NO. 639 S. New Kirk ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of Mazel Breeden

6 DATE OF BIRTH (month, day, and year) April 10, 1861

7 AGE	Years	Months	Days	If LESS than 1 day,... hrs. or min.
	68	1	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Page Co.
(State or country) Virginia

PARENTS

10 NAME OF FATHER Marcus Hitt

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Not Known

14 Informant E. R. Hall
(Address) 639 S. New Kirk St

15 [illegible] G. HAMPSON JONES, M. D. Registrar

MAY 14 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 15 - 1929 to May 13 - 1929

that I last saw her alive on May 13 - 1929

and that death occurred, on the date stated above, at 9 20 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Exophthalmic Goitre

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. H. Herrmann M. D.

May 14 - 1929 (Address) 1913 E Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Schenandoah, Virginia

DATE OF BURIAL May 15 1929

UNDERTAKER Henry Sander & Sons Inc

ADDRESS Baltimore St & Broadway

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45945

CERTIFICATE OF DEATH.

E 45945

T 18 7-001

1-PLACE OF DEATH

REGISTERED NO._____

City of BALTIMORE: (No. Conway Dwgs Hosp from S. U. Cor. 4 St., ____ Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edward Phebus

(a) RESIDENCE NO. 322 Woodland Ave Takoma Park Md St. _____ Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. / ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Florence Phebus

6 DATE OF BIRTH (month, day, and year) _____

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bricklayer

(b) General nature of industry, business, or establishment in which employed (or employer) Oil

(c) Name of employer David C. Butcher

9 BIRTHPLACE (city or town) _____

(State or country) Md

PARENTS

10 NAME OF FATHER Geo Phebus

11 BIRTHPLACE OF FATHER (city or town) _____

(State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) _____

(State or country) Unknown

14 Informant Mrs Vincent

(Address) 869 Park Ave

C. HAMPSON JONES, M. D.

MAY 14 1929 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14. 29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract. of Skull

Accidental - In Elevator while Elevator Starter Coming Had come in contact with a Beam

(duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) Fracture

(duration) ___ yrs. ___ mos. ___ ds.

(Signed) M. T. Price M. D.

May 14 (Coroner)

, 19 29 (Address) 1059 Bonaparte

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.),

At place of death ___ yrs., ___ mos., ___ ds. In the State ___ yrs., ___ mos., ___ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington D. C. Date of Burial May 14th 1929

20 UNDERTAKER Henry Hoeck Sons Inc. ADDRESS 1301 E Eager

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 45946 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 45946

REGISTERED NO.

1-PLACE OF DEATH Franklin Square Hosp

CITY OF BALTIMORE: (No. Calhoun & Fayette ST. 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward C. Schofield -

(a) RESIDENCE No. 1827 W. Lafayette ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married -

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elsie Schofield -

6 DATE OF BIRTH (month, day, and year) May 21 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	58 -	11	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman - 66

(b) General nature of industry, business, or establishment in which employed (or employer) Auto Supply Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md. -

PARENTS

10 NAME OF FATHER William Schofield

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Margaret Long

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland Md.

14 Informant (Address) Mrs. E. Elsie Schofield 1827 W. Lafayette St

15 Filed MAY 15 1929 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1929 -

17

I HEREBY CERTIFY, That I attended deceased from May 9 . 1929 . to May 14 . 1929 . that I last saw him alive on May 14 . 1929 . and that death occurred, on the date stated above, at 2:05 P m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia.

(duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings.

(Signed) Elizabeth B. Shenton, M. D.

5/14 . 1929 (Address) Franklin Square Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem. DATE OF BURIAL May 17" 1929

20 UNDERTAKER Robert Cook ADDRESS 1003 Mt Ave

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45947 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 45947

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1924 Lemon ST. 19-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edgar Galvin

(a) RESIDENCE NO. 1924 Lemon ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillien Galvin

6 DATE OF BIRTH (month, day, and year) Jan. 17, 188[illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	3	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher 813

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Greenwald Packing Co

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER William J. Galvin

11 BIRTHPLACE OF FATHER (city or town) Howard Co (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah A. Litchfield

13 BIRTHPLACE OF MOTHER (city or town) Avolin (State or country) [illegible], Maryland

14 Informant Mrs. John F. Yinger

(Address) 511 N. Market St.

15 Filed [illegible] 19[illegible] HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 11, 1929. to May 14, 1929.

that I last saw h[illegible] alive on May 14, 1929.

and that death occurred, on the date stated above, at 1.45 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. O'Neill M. D.

5/14, 1929 (Address) 108 N. Fulton Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL [illegible] Loudon Park Cemetery

DATE OF BURIAL May 17 19 29

ADDRESS [redacted] West Baltimore St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is important. See instructions on back of certificates.

A 157529 BRK

Superintendent 1850

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45948

CERTIFICATE OF DEATH

90

E 45948

1—PLACE OF DEATH

REGISTERED NO. 11-24

CITY OF BALTIMORE: (No. Union Memorial Hosp ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Pere Wilmer Little

(a) RESIDENCE NO. 1213 Linden Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Caroline E. Little

6 DATE OF BIRTH (month, day, and year) Mar. 20, 1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40 yrs 48	1	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Vice-pres. Surety Co

(b) General nature of industry, business, or establishment in which employed (or employer) Trust Co

(c) Name of employer Fidelity & Deposit Co

9 BIRTHPLACE (city or town) (State or country) Queenstown, Kent Co., Md.

PARENTS

10 NAME OF FATHER T. T. Little

11 BIRTHPLACE OF FATHER (city or town) Balto., Md. (State or country)

12 MAIDEN NAME OF MOTHER Katherine Wilmer

13 BIRTHPLACE OF MOTHER (city or town) Queenstown, Md. (State or country)

14 Informant Mrs. Wife Caroline E. Little

(Address) 1213 Linden Avenue

Filed MAY 15 1929, 19 C. HAMPSON JONES, M. D.

By Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 4, 1922, to May 14, 1929, that I last saw him alive on May 14, 1929 and that death occurred, on the date stated above, at 1:45 a.m.

The CAUSE OF DEATH* was as follows:

Arteio - Sclerotic Cardio Vascular Disease & generalized Arterio-Sclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? None

(Signed) C. Alvan Jones, M. D.

5/14, 1929 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Prince Frederick, Md.

DATE OF BURIAL May 16 1929

20 UNDERTAKER Joseph E. Cook

ADDRESS 1003 West Baltimore St

IMPORTANT: CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

Kay Ramer

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45949

CERTIFICATE OF DEATH

167-001

E 45949

1-PLACE OF DEATH

City of Baltimore: (No. 1525 Alice Anne St., Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Kay Ramer

(a) RESIDENCE NO. 1525 Alice Anne St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of No.

6 DATE OF BIRTH (month, day, and year) No. 1884

7 AGE 45 Years — Months — Days | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) No.
(c) Name of employer

9 BIRTHPLACE (city or town) Lithvania
(State or country)

PARENTS

10 NAME OF FATHER No.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Lithvania

12 MAIDEN NAME OF MOTHER No.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Lithvania

14 Informant Chas Zilaitis
(Address) 612 E Lombard St.

Filed MAY 15 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above. The CAUSE OF DEATH was as follows:

Suicide

Gas Poison Ill

(duration) yrs. mos. 4hs.

CONTRIBUTORY (Secondary) A Physical

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy?

What was confirmed diagnosis?

(Signed) H. C. Elder Jr.

. 19 (Address) 143 Robert Way M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Russian Independet	May 15. 1929
20 UNDERTAKER	ADDRESS
John Grebliauckas	425 S Paca St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45950

CERTIFICATE OF DEATH.

100-001

E 45950

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1428 Mosher (ST.) (WARD) 14-20

2-FULL NAME Richard Whitfield

(a) RESIDENCE NO. 1428 Mosher ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Julia Whitfield

6 DATE OF BIRTH (month, day, and year): 1884

7 AGE: Years 44 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer): Public Work

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Massachusetts

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Julia Whitfield (Address) 1428 Mosher St

15 Filed MAY 15 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/13/29

17 I HEREBY CERTIFY, That I attended deceased from 4/27 19 29, to 5/13 19 29, that I last saw h alive on 5/13 19 29, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary) Hard work & Exposure

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No (Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. C. Ellis M. D.

(Address) 924 Whitelock

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: May 15 1929

20 UNDERTAKER: Virginia A Brooks — ADDRESS: 1463 N. Carey

WRITE PLAINLY, with unfading ink. All the information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 45951

129

E 45951 REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3436 Hickory Ave ST 13-5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ivy S. Lucabaugh.

(a) RESIDENCE NO. 3436 Hickory Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): single.

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept 22 1878

7 AGE: Years 50 Months 7 Days 22 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Mill Hand

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): md

PARENTS

10 NAME OF FATHER: Peter Lucabaugh.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Elizabeth Shaum.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Elizabeth Lucabaugh

(Address): 3436 Hickory Ave

15 Date: MAY 15 1929 Registered: HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 14 1929.

17 I HEREBY CERTIFY, That I attended deceased from May 12 19 29 to May 14 19 29 that I last saw her alive on May 14 19 29 and that death occurred, on the date stated above, at 9:30 a. m.

The CAUSE OF DEATH* was as follows:

(a) Chronic nephritis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urinal exam

(Signed) C. F. Culpepper M. D.

5/14 19 29 (Address) 320 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Peters Carroll Co — DATE OF BURIAL: May 17, 1929.

20 UNDERTAKER: C. Emanuel Shaum — ADDRESS: 3615 Eastern Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45952 — 74-201 — E 45952

CERTIFICATE OF DEATH

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 208 W. Washington ST. 6-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frances J. Lachner

(a) RESIDENCE NO. 208 W. Washington ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 26 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	64	7	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Leonard Jung

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germ.

12 MAIDEN NAME OF MOTHER Frances Deck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germ

14 Informant Sophie Loewer
(Address) 208 W. Wash. st

15 [illegible] 19 [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-17-29

17 I HEREBY CERTIFY, That I attended deceased from 5-9, 1929 to 5-17, 1929, that I last saw her alive on 5-14, 1929 and that death occurred, on the date stated above, at 2 00 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Leonard Levy M. D.

5/17 19 29 (Address) 415 N Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	May 19 1929

20 UNDERTAKER Jos J. Kerr — ADDRESS 156 N. Luzerne

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAY 15 1929 [illegible] SANITARY BUREAU

Spec.—2-29-28—L. F. S.—500 Blks.

E 45953

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓ E 45953

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3205 E. Fairmount Ave ST. 17th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jane Brough

(a) RESIDENCE NO. 3205 E. Fairmount ave ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Widow

a If married, widowed, or divorced HUSBAND of (or) WIFE of John Brough

6 DATE OF BIRTH (month, day, and year) Oct 1848

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or ... min.
80	7	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Canada

PARENTS

10 NAME OF FATHER Wm. Frousyth

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Rebecca Huffet

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Ida Fouts

(Address) 3205 Fairmount ave

15 FILED MAY 15 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12/29

17 I HEREBY CERTIFY, That I attended deceased from May 11, 1929, to May 12, 1929

that I last saw h[illegible] alive on May 12, 1929

and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows:

Arteri. Sclerosis

Myocarditis

Acute Bronchitis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Myocarditis Chronic Bronchitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Antignani, M. D.

(Address) 2942 E. Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem

DATE OF BURIAL 5/15/1929

20 UNDERTAKER J. A. Moran

ADDRESS 300 E Baltimore

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45954

CERTIFICATE OF DEATH.

118-001

REGISTERED NO. E 45954

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital ST. 3-5 WARD)

2-FULL NAME Freida Bugatch.

(a) RESIDENCE NO. [redacted] Lloyd St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? 19 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Bugatch

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE: Years 60 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Aaron Slobkin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Pinkus

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Jack Lewis

(Address) 1434 E. Baltimore St

15 Filed MAY 15 1929 19

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/14 1929

17

I HEREBY CERTIFY, That I attended deceased from 5/12 1929 to 5/14 1929

that I last saw h[illegible] alive on 5/14 1929

and that death occurred, on the date stated above, at 5:10 P. m.

The CAUSE OF DEATH* was as follows:

Strangulated Umbilical Hernia.

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary): Acute Cardiac Dilatation.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. E. Goodman, M. D.

5/14 1929 (Address) Sinai Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale

DATE OF BURIAL: 5/15 1929

20 UNDERTAKER: Jack Lewis

ADDRESS: 1434 E Baltimore St

8.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45955

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45955

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO. 100001

CITY OF BALTIMORE: (No. ..... ST., No 3 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Solomon Moore or MEARS

(a) RESIDENCE NO. Unknown ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records of
(Address) Baltimore City Hospitals

15 ....., 19 C. HAMPSON JONES, M. D. Registrar

MAY 15 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 11, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 22, 1929 to May 11, 1929, that I last saw h im alive on May 11, 1929 and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchio Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Physical Exam

What test confirmed diagnosis?

(Signed) Warren M. McClain, M. D.

, 19 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Hebrew

DATE OF BURIAL 5-15 1929

20 UNDERTAKER Jack Lewis, 1929

ADDRESS E Balto St

Information should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 45956 (1926) HEALTH DEPARTMENT—CITY OF BALTIMORE E 45956

CERTIFICATE OF DEATH.

31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 8-17 WARD)

2-FULL NAME Gaetano Crivello

(a) RESIDENCE NO. 1919 E Northern ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? 30 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Angelina Crivello

6 DATE OF BIRTH (month, day, and year) June 21 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	10	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cement Worker

(b) General nature of industry, business, or establishment in which employed (or employer) 883

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Joseph

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Anna Piston

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed MAY 15 1929 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1929

17 I HEREBY CERTIFY, That I attended deceased from May 7, 1929, to May 13, 1929, that I last saw him alive on May 13, 1929, and that death occurred, on the date stated above, at 11:30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) ? yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Probably septicaemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ~~unknown~~

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Sputum examination

(Signed) W. Keiper, M. D.

May 15 1929 (Address) J. H. Hosp. Balt.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL May 17 1929

20 UNDERTAKER Henry Hoedt Sons Inc. — ADDRESS 1801 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 45957

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45957

CERTIFICATE OF DEATH

8-13 17

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Johns Hopkins Hospital St., 8 Ward)

2-FULL NAME Conrad G. Killmayer

(a) RESIDENCE NO. 1108 N. Washington St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 53 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Margaret Killmayer

6 DATE OF BIRTH (month, day, and year) May 14/1876

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	53	0	0	

8 OCCUPATION OF DECEASED
(a) Trade, professinn nr particular kind of wnrk House Painter 0
(h) General naturo of industry, business, or establishment in which employed (or employer) 0
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Conrad Killmayer

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Bucher

13 BIRTHPLACE OF MOTHER (city or tnwn)
(State or country) Germany

14 Informant Mrs. Grace Kripple
(Address) 1108 N. Washington St

15 Filed ..... 19.. HARRY JONES, M. D. Registrar

MAY 15 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock-Fractured leg etc.
Jumped out 3rd story window at home
(Suicide)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hem. several yrs ago.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. F. Cullen, M. D.

5/15/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Hnmicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL May 18 19 29

20 UNDERTAKER Henry Hoeck Sons Inc. — ADDRESS 1301 E Eager St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45958

CERTIFICATE OF DEATH

100-001

E 45958

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2714 Southern Ave St. 27-24 WARD)

2—FULL NAME Andrew Betz

(a) RESIDENCE NO. 2714 Southern Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if foreign birth? 74 yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Betz

6 DATE OF BIRTH (month, day, and year) July 9/1850

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
78	10	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Sailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Betz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Adolph Miller
(Address) 2714 Southern Ave

15 Filed MAY 15 1929 THOMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13/29

17 I HEREBY CERTIFY, That I attended deceased from April 25 1929 to May 15 1929 that I last saw him alive on May 12" 1929 and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Acute Nephritis
Broncho Pneumonia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Age.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Leonard B. Gibson, M. D.

5/14 1929 (Address) 3706 Liberty Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Cem.	May 15 1929
UNDERTAKER Philip Herwig	ADDRESS 2016 Orleans St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45959

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

38 E 45959

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Balto City Hosp ST. 3-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jeannette Bedford

(a) RESIDENCE NO. 108 S. Bond ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Walter Bedford

6 DATE OF BIRTH (month, day, and year) Entered 8 96

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Josephine ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Walter Bedford
(Address) 108 S. Bond St.

15 Filed MAY 15 1929 LAWSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-12-29

17 I HEREBY CERTIFY, That I attended deceased from 4/16, 1929, to 5/12, 1929, that I last saw h.. alive on 5/12, 1929 and that death occurred, on the date stated above, at 1 30 p. m.

The CAUSE OF DEATH* was as follows:

Aneurysm Abdominal Aorta

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Ruptured Aneurysm

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. U. Lumpkins, M. D.

5/12. 1929 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
North Point cemetery	May 15 1929
20 UNDERTAKER Wm. R. A. Elliott	ADDRESS 725 Washington

INFORMATION should be carefully supplied. NOTE should be taken that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-20-28—L. F. S.—500 Bks.

E 45960

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-802

E 45960

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE (No.) 850 W. 35 ST., (WARD) 13-54

2—FULL NAME Wilhelmina H. C. Gibson

(a) RESIDENCE NO. 850 W. 35 ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Charles H. Gibson

6 DATE OF BIRTH (month, day, and year) Nov 18-1882

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	43	5	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co

PARENTS

10 NAME OF FATHER Henry Schultz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dorothy Jaeger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. Charles H. Gibson

(Address) 850 W. 35 St

15 MAY 15 1929 HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14-29

17

I HEREBY CERTIFY, That I attended deceased from Jan, 1929, to May 14, 1929,

that I last saw h[illegible] alive on May 13, 1929

and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Cerebral arteriosclerosis of the embrain

2

CONTRIBUTORY (Secondary) Myocardial insufficiency (duration) yrs. mos. 7 ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? Examin

(Signed) [illegible], M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge DATE OF BURIAL May 16 1929

20 UNDERTAKER A S Marshall ADDRESS 2539 Pall Road

Information should be carefully supplied. Accurate answers to questions on OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 45961 90 E 45961

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Union Memorial Hosp. WARD) 27-55

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Alice Warfield Gill

(a) RESIDENCE NO. 300 Wyndhurst Ave ST., City WARD
(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martin Gillette Gill

6 DATE OF BIRTH (month, day, and year) May 28, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77		16	
	78 yrs			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Howard Co., Md

PARENTS

10 NAME OF FATHER Albert Warfield

11 BIRTHPLACE OF FATHER (city or town) (State or country) Howard Co. Md

12 MAIDEN NAME OF MOTHER Margaret Watkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Howard Co. Md.

14 Informant Hospital Records

(Address)

15 MAY 15 1929, 19 [illegible] JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14, 1929

17

I HEREBY CERTIFY, That I attended deceased from April 2, 19 29, to May 14, 19 29, that I last saw h.er alive on May 14, 19 29, and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH* was as follows:

Arteria - Sclerotic Cardio - Vascular Disease & Cerebral Embolism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? none

(Signed) H. Halsman Jones, M. D.

, 19 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — DATE OF BURIAL May 16, 19 29

20 UNDERTAKER Edward W. Moser & Co — ADDRESS Balto

Spec.—12-9-25—A Co.—200 Bks.

E 45962

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 E 45962

REGISTERED NO.

1-PLACE OF DEATH Church Home & Inf.

City of BALTIMORE: (No. Broadway & Fairmount St. 9448 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Catharine Sadtler

(a) RESIDENCE NO. 6300 Mayflower Rd St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): August 1849

7 AGE — Years: 79 Months: 9 Days: IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town)

(State or country): Penna

PARENTS

10 NAME OF FATHER: Benj. Sadtler

11 BIRTHPLACE OF FATHER (city or town) Balto

(State or country): Maryland

12 MAIDEN NAME OF MOTHER: Caroline Schmucker

13 BIRTHPLACE OF MOTHER (city or town) Mt. Airy

(State or country): Va.

14 Informant: Rev. John G. Sadtler (Bro)

(Address) McLean-Va.

Filed MAY 15 1929 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 14 1929

17 I HEREBY CERTIFY, That I attended deceased from May 11, 1929, to May 14, 1929, that I last saw her alive on May 13, 1929 and that death occurred, on the date stated above, at 4:15 p.m.

The CAUSE OF DEATH* was as follows:

Cardiac failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

chr. Nephritis (duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Walter B. Johnson, M. D.

May 19 29 (Address) Church Home & Inf

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Hill Cemetery Date of Burial May 16 1929

20 UNDERTAKER: Stewart & Smith Co. ADDRESS Balto.

R.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45963

CERTIFICATE OF DEATH

90

REGISTERED NO. E 45963

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3819 Fourth Ave ST., Wagners Point WARD) 25-16

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Martin J. Lightner

(a) RESIDENCE NO. 3819 Fourth Ave. ST., Wagners Point WARD 25

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. 2 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine M. Lightner

6 DATE OF BIRTH (month, day, and year) May 12th 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37		2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steel Mill Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Inter Ocean Oil Works

(c) Name of employer Wagners Paint

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Michael Lightner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Margaret Ford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Catherine M. Lightner

(Address) 3819 Fourth Ave. Wagners Point

15 Filed ... 19 ... HAMILTON JONES, M. D. Registrar

MAY 15 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14th 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 5 1928, to May 13 1929

that I last saw him alive on May 13 1929

and that death occurred, on the date stated above, at 1:05 a. m.

The CAUSE OF DEATH* was as follows: Mitral Regurgitation

Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) General Anasarca

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Leon D. Hudson M. D.

5/14 1929 (Address) 4700 Pennington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	May 18th 1929
20 UNDERTAKER Lilly + Zeiler Inc.	ADDRESS 400 S. Wolfe St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45964

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

118-002 ✓ E 45964

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 739 S. Linwood Ave. ST. 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William A. Laty

(a) RESIDENCE NO. 739 S. Linwood Ave ST. 1 WARD
(Usual place of abode)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if foreign birth? 36 yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna M. Laty

6 DATE OF BIRTH (month, day, and year) Mch 1st 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	1 2	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waterman for City

(b) General nature of industry, business, or establishment in which employed (or employer) City Dept of Water

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Alfred Laty

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anna M. Laty Wife

(Address) 739 S. Linwood Ave

Filed MAY 15 1929. H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13th 29

17 I HEREBY CERTIFY, That I attended deceased from May 12, 1929, to May 13, 1929

that I last saw h[illegible] alive on May 13, 1929

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) General peritonitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? P. S. & S.

(Signed) John V. Szczerbicki M. D.

(Address) 735 S. Linwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart Cemetery — DATE OF BURIAL: May 16 19 29

20 UNDERTAKER: Lilly + Geiler Inc — ADDRESS: 402 N. Wolfe St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45965

CERTIFICATE OF DEATH.

188-103

27-43

E 45965

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. Enroute to St. Joseph Hospital St. ____ Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Clinton R. Gosnell.

(a) RESIDENCE NO. 2909 Louise Ave. St. ____ Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. 3 mos. 23 ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edith E. Gosnell.

6 DATE OF BIRTH (month, day, and year) Jan. 21, 1900

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	29.	3.	23.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cab Chauffeur 23

(b) General nature of industry, business, or establishment in which employed (or employer) Yellow Cab Co.

(c) Name of employer

9 BIRTHPLACE (city or town) ____

(State or country) Balto. Md

PARENTS

10 NAME OF FATHER Douglas Gosnell.

11 BIRTHPLACE OF FATHER (city or town) ____

(State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Ida Yeteman

13 BIRTHPLACE OF MOTHER (city or town) ____

(State or country) Balto. Md.

14 Informant Edith E. Gosnell.

(Address) 2909 Louise Ave.

15 Filed MAY 15 1929 G. HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ____ (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ____ (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull(Base)
Thrown from Automobile Harford Ave near Parkside Drive. Accidental.

____ (duration) ___ yrs. ___ mos. ___ ds.

CONTRIBUTORY (Secondary) ____ (duration) ___ yrs. ___ mos. ___ ds.

(Signed) J. S. Coates M. D.
(Coroner)

5/15/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ___ yrs., ___ mos., ___ ds. In the State ___ yrs., ___ mos., ___ ds.

Where was disease contracted, if not at place of death? ____

Former or usual residence ____

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

U. S. National Cem May 16, 1929

20 UNDERTAKER A. Howard Evans ADDRESS 38 E Fort Ave

R.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

223158

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45966

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

X 90 E 45966

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kalliopi Christofi

(a) RESIDENCE NO. Roanoke Va ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX f

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of [illegible]

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or ... min.
36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H W

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) British Col

PARENTS

10 NAME OF FATHER Kyriakos —

11 BIRTHPLACE OF FATHER (city or town) (State or country) British Col

12 MAIDEN NAME OF MOTHER Helen —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) British Col

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed MAY 15 1929 19

C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1929

17 I HEREBY CERTIFY, That I attended deceased from May 8 . 1929 . to May 12 . 1929 . that I last saw her alive on May 12 . 1929 , and that death occurred, on the date stated above, at 7.30 p m.

The CAUSE OF DEATH* was as follows:

Chronic Rheumatic Endocarditis

Mitral Stenosis • Insufficiency

Myocardial Insufficiency.

(duration) 3 yrs — mos — ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) W. Brigg M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem DATE OF BURIAL May 15 1929

20 UNDERTAKER Robert Brookerson ADDRESS Calhoun Hollins Sts

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Dr Campbell Med Examiner 5th

E 45967

HEALTH DEPARTMENT—CITY OF BALTIMORE

122-002

E 45967

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1622 Light ST., 23-3E WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Cornelious Colwell

(a) RESIDENCE NO. 1622 Light ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Nora Colwell

6 DATE OF BIRTH (month, day, and year) Jan 25, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	3	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs Lorena Friedman

(Address) 1622 Light St

15 Filed MAY 15 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12, 1929

17 I HEREBY CERTIFY, That I attended deceased from Mar 10, 1929, to May 12, 1929

that I last saw h~~e~~alive on May 12, 1929

and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(Non alcoholic)

(duration) Indefinite yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. E. Campbell, M. D.

5/16, 1929 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Leakin Hill

DATE OF BURIAL 5/15 1929

20 UNDERTAKER J. M. Cook

ADDRESS 1217 Fulton St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45968

CERTIFICATE OF DEATH.

129

E 45968

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1126 W. Lexington ST.) (WARD) 18-26

2-FULL NAME Nicholas Albert Smallwood

(a) RESIDENCE NO. 1126 W. Lexington ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lydia Smallwood

6 DATE OF BIRTH (month, day, and year) Oct ? 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	7	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Musician do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Lydia Smallwood

(Address) 710 E. Eutaw

15 MAY 15 1929 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1929

17

I HEREBY CERTIFY, That I attended deceased from Apr 15, 1929 to May 12, 1929.

that I last saw h[illegible]ive on May 11, 1929,

and that death occurred, on the date stated above, at 4 A. m

The CAUSE OF DEATH* was as follows:

Chronic Interstitual Nephritis

(duration) 1 yrs. ? mos ? ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urinary

(Signed) C Smoke, M. D.

5/14 1929 (Address) 1106 Druid Hill

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	May 17 1929
20 UNDERTAKER	ADDRESS
Walter B. Spriggs	137 Hanover

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 45969

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45969

CERTIFICATE OF DEATH

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH

City of Baltimore: (No. 758 W. Hamburg St. 21-29 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Allen McNeal

(a) RESIDENCE NO. 758 W. Hamburg St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 19-1900

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	28	4	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Va

PARENTS

10 NAME OF FATHER James McNeal

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Mary Annie

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Cal.

14 Informant Eugene McNeal
(Address) 1500 Williams St.

Filed MAY 15 1929 C. HUDSON JONES, M.D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 6 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

(a) Poisoning, Administering Gas Suicide

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zeller M. D.

5/14 1929 (Address) 2739 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem Co

DATE OF BURIAL 5-16 1929

20 UNDERTAKER Leonard C Hahn

ADDRESS 1000 Race St.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 45970

E 45970

CERTIFICATE OF DEATH.

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1628 Jefferson ST., 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Griffin

(a) RESIDENCE No. 1628 Jefferson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Griffin

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER Hargus Griffin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Ella Griffin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Mary Griffin (Address) 1628 Jefferson St.

15 C. HAMILTON JONES, M. D. Registrar

Per

MAY 15 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12 1929.

17 I HEREBY CERTIFY, That I attended deceased from May 10 . 1929 to May 11 . 1929. that I last saw him alive on May 11 . 1929, and that death occurred, on the date stated above, at 6 A. m.,

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Robert J. Green M. D.

5-13-1929 (Address) 120 Aisquith St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary Cem. DATE OF BURIAL May 16 1929

20 UNDERTAKER Carl J. G. Locks ADDRESS 1302 Jeffers

WARNING—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45971

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45971

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 117

CITY OF BALTIMORE: (No. Balto. City Hosp. ST. 16-31 East WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank Francesco Francesi Franco.

(a) RESIDENCE NO. 713 Lough St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single.

6 DATE OF BIRTH (month, day, and year):

7 AGE — Years: 59 ? | Months: | Days: | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER Felix Francesco

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER Anna Carelli

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: Wendell J. Hoyt (Address): 300 S. Eden St.

15 C. HAMPSON JONES, M. D. Registrar

MAY 15 1929 Per Clerk

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/12/29

17

I HEREBY CERTIFY, That I attended deceased from 5/9, 1929, to 5/12, 1929,

that I last saw h/ alive on 5/12, 1929

and that death occurred, on the date stated above, at 12.50 P. m.

The CAUSE OF DEATH* was as follows:

Gangrenous appendicitis

Diffused peritonitis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? yes Date of 5/9/29

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) L. L. L. Crumpton, M. D.

5/12, 1929 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Stanislaus

DATE OF BURIAL: May 15 1929

20 UNDERTAKER: Wendell J Hoyt

ADDRESS: 300 S Eden

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 45972

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 45972

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1530 Leslie St. 15-21 Ward)

2-FULL NAME John Walker Payne.

(a) RESIDENCE NO. 1530 Leslie St. St. Ward Richmond Va.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Annie E Payne

6 DATE OF BIRTH (month, day, and year) Dec 16 1873

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	55	4	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Proprietor & Grocery Store

(b) General nature of industry, business, or establishment in which employed (or employer) 034

(c) Name of employer

9 BIRTHPLACE (city or town) Norfolk Co.

(State or country) Virginia

PARENTS

10 NAME OF FATHER Enoch Payne

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Sarah Walker.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Virginia

14 Informant Annie E. Payne.

(Address) 1530 Leslie St.

15 Filed C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1929

17 I HEREBY CERTIFY, That I attended deceased from May 10- 1929, to May 14 1929, that I last saw h.im alive on May 13- 1929, and that death occurred, on the date stated above, at 11:05 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) none

(duration) — yrs. — mos. — ds.

18 Where was disease contracted

If not at place of death? unknown

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? physical signs & urinalysis

(Signed) Chester Ruland, M. D.

5-14- 1929 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem. Date of Burial May 16 1929

20 UNDERTAKER Wm Wickner & Sons ADDRESS North & Pa

P. S.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAY 15 1929

Spec.—1-10-21—M&T—1500 Blks.

E 45973 HEALTH DEPARTMENT—CITY OF BALTIMORE E 45973

CERTIFICATE OF DEATH.

REGISTERED NO. 161-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST. 3-4 WARD)

2-FULL NAME Baby Majica

(a) RESIDENCE No. 814 S. Bond ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 ~~Single~~, Married, Widowed, or Divorced (write the word)

~~5a~~ If married, widowed, or divorced HUSBAND of (or) WIFE of ~~of~~

6 DATE OF BIRTH (month, day, and year) Feb. 17th 1929

7 AGE Years ..... Months 3 Days 25 If LESS than 1 day, hrs. ..... or min. 84

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) ~~.....~~ Food

(c) Name of employer ~~.....~~

9 BIRTHPLACE (city or town) ..... (State or country) Md.

PARENTS

10 NAME OF FATHER Jacpar Majica

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Porto Rico

12 MAIDEN NAME OF MOTHER Andia Velez

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Porto Rico

14 Informant Alan Gutmacher M.D.
(Address) Johns Hopkins Hospital

15 MAY 15 1929 C. HAMPSON JONES, M. D. Registrar
Per RCH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 12th 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb. 17, 1929, to May 12, 1929, that I last saw ~~him~~ alive on May 12, 1929, and that death occurred, on the date stated above, at 5.45 A. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Alan Gutmacher M.D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL ..... DATE OF BURIAL 19

20 UNDERTAKER ..... ADDRESS .....

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 45974 HEALTH DEPARTMENT—CITY OF BALTIMORE E 45974

CERTIFICATE OF DEATH.

161-001

1-PLACE OF DEATH

City of BALTIMORE: (No. 815 Lemmon Ave. St. 17-24 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Lee

(a) Residence No..... St., ... Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Black

5-Single, Married, ~~Widowed~~, or Divorced (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 13th 1929

7-AGE, ... yrs. ..... mos. ..... ds. If LESS than 1 day, 7 hrs. or 50 min.?

8-OCCUPATION OF DECEASED

(a) Trade, professiou, or particular kind of work.....

(b) General nature of industry, business, or establishmeut in which employed (or employer)..... ad

(c) Name of employer.....

9-BIRTHPLACE (city or town)..... Balto. Md.
(State or Country),

PARENTS.

10-NAME OF FATHER, C. J. Lee

11-BIRTHPLACE OF FATHER (city or town)..... Pittsmoore
(State or Country), Penn.

12-MAIDEN NAME OF MOTHER, Annie Matthews

13-BIRTHPLACE OF MOTHER (city or town)..... Bound Co.
(State or Country), Me.

14-

(Informant).....

(Address)..... JOHNS HOPKINS HOSPITAL

15-

Filed ..... 19.... C. HANSON JONES, M. D. Registrar.

MAY 15 1929 Reg. 3586

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 13th 1929

17- I HEREBY CERTIFY, That I attended deceased from May 13 1929 to May 13 1929 that I last saw h alive on May 13 1929 and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Emma Entity (32 wks)

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Louis T. Hardy Jr. M. D.

5/14 1929 (Address) Mass. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL ..... DATE OF BURIAL, ... 19....

20-UNDERTAKER, Commissioner Health. ADDRESS

MAY 15 1929

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45975

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001 ✓

E 45975

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1818 Ashburton ST. 15-68 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William F. Schindele

(a) RESIDENCE NO. 1818 Ashburton ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, or ~~Divorced~~, (write the word)
Male	white	widowed

6a If married, widowed, or divorced
HUSBAND of
~~(or) WIFE~~ of Anna M. Schindele

6 DATE OF BIRTH (month, day, and year) Sept 18, 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
84 85		7 8	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Jacob Schindele

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Gibser

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary Westeatte

(Address) 1818 Ashburton St.

15 MAY 15 1929

G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 3, 1925, to May 15, 1929

that I last saw him alive on May 14, 1929

and that death occurred, on the date stated above, at 5:00 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 20 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. K. Ogden M. D.

5/15/29 (Address) 2757 W. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Emmanuel Cemetery	May 17, 1929

20 UNDERTAKER Robt. F. Funnell ADDRESS 472 Broadway

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45976

CERTIFICATE OF DEATH

REGISTERED NO. 100-001 E 45976

1—PLACE OF DEATH 2001 Park ave

CITY OF BALTIMORE: (No.) Druker Home St. 13-20 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rebecca Hollingsworth

(a) RESIDENCE NO. 2001 Park Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. — mos. — ds. — How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 31-1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	76	11	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Orrin W. Hollingsworth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Lorie Clement.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Vermont.

14 Informant Mrs Clyde Rahill

(Address) Talleston Md.

15 Filed ....., 19 HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15-1929

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1929, to May 15, 1929, that I last saw h.e alive on May 15, 1929 and that death occurred, on the date stated above, at 18, m.

The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical symptoms.

(Signed) C. F. Robinson, M. D.

5/15. 1929 (Address) 836 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Friends cem Harford Co Md — DATE OF BURIAL May 18 1929

20 UNDERTAKER Hornberger & Gross — ADDRESS Bel Air Md.

MAY 15 1929

MAY 15 1929

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 45977

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 45977

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Saint Josephs Hospital WARD)

2—FULL NAME Alice Jefferson

(a) RESIDENCE NO. 3212 Fait Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles H. Jefferson

6 DATE OF BIRTH (month, day, and year) Jan. 3. 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER John M. Freshour

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Catherine Bucky

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mr. Chas. H. Jefferson (Husband)

(Address) 3212 Fait Ave.

15 Filed ..... 19 ..... CHAMPSON JONES, M. D. Registrar

Per .....

MAY 15 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/14/29

17

I HEREBY CERTIFY, That I attended deceased from May 9, 1929, to May 14, 1929

that I last saw her alive on May 14, 1929

and that death occurred, on the date stated above, at 10.30 P. m.

The CAUSE OF DEATH* was as follows:

Appendicitis.
Pleurisy

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? yes Date of 4/10/29

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cemetery	May 17 1929
20 UNDERTAKER	ADDRESS
Henry Sander & Sons. Inc	Baltimore St. & Broadway

S. B.—WRITE PLAINLY, WITH CAPABILITY. ... CAUSE ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should ... OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION ... important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45978 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

113 E 45978

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 605 S. Milton Ave ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Stanislaus Chmiel

(a) RESIDENCE NO. 605 S. Milton Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 11 1929

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....mln.
	4	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Chmiel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Aniela Dul

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Aniela Chmiel

(Address) 605 S Milton Ave

15 C. HAMPSON JONES, M. D. Registrar

MAY 15 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1929

17 I HEREBY CERTIFY, That I attended deceased from May 5 1929, to May 15 1929

that I last saw h[illegible] alive on May 15 1929

and that death occurred, on the date stated above, at 5a m.

The CAUSE OF DEATH* was as follows:

Atrophia Infantum
due to malnutrition

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) Cardiac Exhaustion

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm F. Rydanek M. D.

May 15 1929 (Address) 801 N Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	May 16 1929

20 UNDERTAKER ADDRESS

John M Weber 401 N Chester Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should [illegible] CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45979

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

51 E 45979

REGISTERED NO. 27-43

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3105 Northern Park Way ST., (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John C. Jaworski

(a) RESIDENCE NO. 3105 Northern Park Way ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Jaworski

6 DATE OF BIRTH (month, day, and year) June 1 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36	11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Furniture Store

(b) General nature of industry, business, or establishment in which employed (or employer) Business

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Frank Jaworski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Mollie Karwacka

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Anna Jaworski
(Address) 3105 Northern Park Way

15 C. HAMPSON JONES, M. D.
Registrar

MAY 15 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1929

17 I HEREBY CERTIFY, That I attended deceased from May 7, 1929, to May 14, 1929, that I last saw him alive on May 14, 1929, and that death occurred, on the date stated above, at 4a m.

The CAUSE OF DEATH* was as follows:

Acute Rheumatic Fever
Cerebral Rheumatism
Endocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Andrew Kwiecinski, M. D.

5/14, 1929 (Address) 2579 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stanislaus Kostka — DATE OF BURIAL 17 1929

20 UNDERTAKER John M Weber 731 S Chester — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Dr Evans, 918 N. York St

E 45980

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 45980

1—PLACE OF DEATH

REGISTERED NO. 20-71

CITY OF BALTIMORE: (No. 115 S Collins Ave ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Kate Herbst

(a) RESIDENCE NO. 115 S Collins Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of Gustave Herbst

6 DATE OF BIRTH (month, day, and year) Jan 2, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	3	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Gottlieb Layer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Lochmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Victor L Emerman

(Address) 231 E Fenton Ave

15 [illegible] 19 HAMPSON JONES, M. D.
Registrar

MAY 19 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14, 1929

17

I HEREBY CERTIFY, That I attended deceased from April 19, 1929 to May 14, 1929, that I last saw h alive on May 13, 1929 and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical.

(Signed) John N Evans, M. D.

May 14 1929 (Address) 612 W 40 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	May 16 19 29
20 UNDERTAKER J. A. Cook	ADDRESS 2120 Eutaw

I.—WHITE PEOPLE, WITH CAUSE OF DEATH. mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

In Mongatiog

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45981

E 45981

CERTIFICATE OF DEATH

101

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2407 Guilford Ave ST., 12-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Christian

(a) RESIDENCE NO. 2407 Guilford Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lee Christian

6 DATE OF BIRTH (month, day, and year): Sept 1859

7 AGE: Years 69 | Months 8 | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: At Home

9 BIRTHPLACE (city or town) (State or country): Bath Me

PARENTS

10 NAME OF FATHER: Patrick Mara

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Hannah Tracy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs M Callahan

(Address) 2407 Guilford Ave

Filed MAY 15 1929 C. HAMPSON JONES, M. D. Registrar

By ADH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 13, 1929

17 I HEREBY CERTIFY That I attended deceased from May 3rd, 19 29, to May 13th, 19 29

that I last saw h[illegible] alive on May 13th, 19 29

and that death occurred, on the date stated above, at 9.55 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Cholecystitis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Thomas Hamilton Hill M. D.

5/14/19 29 (Address) 401 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: 5/16 19 29

20 UNDERTAKER: J. W. Cook

ADDRESS: 1711 Pulaski St

N.B.—WRITE PLAINLY, WITH CARBON PAPER UNDER THIS SHEET. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 45982

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 45982

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4114 St Thomas Ave ST. 27-41 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Russell E Duffield

(a) RESIDENCE NO. 4114 St Thomas Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 2, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		2	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Russell E Duffield

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Grace Myran

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant (Russell E Duffield)
(Address 4114 St Thomas Ave)

15 [illegible] 19 HAMPSON JONES M.D. Registrar

5-24 15129

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1929

17 I HEREBY CERTIFY, That I attended deceased from May 13, 1929, to May 15, 1929, that I last saw him alive on May 14, 1929, and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Congenital Cardiac Malformation

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death.

Did an operation precede death? no Date of —

Was there an autopsy? no —

What test confirmed diagnosis? Clinical

(Signed) Robert Duffy, M. D.

5/15, 1929 (Address) 4 E. Preston st

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Hill Cem

DATE OF BURIAL 5/16 1929

20 UNDERTAKER J. H. Cook

ADDRESS 1217 E Pratt St

N. B.—WRITE PLAINLY, WITH CAPABLE INK. Use a typewriter if possible. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45983

CERTIFICATE OF DEATH

118-002

E 45983

1—PLACE OF DEATH University Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. 2 ST., 24-33 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thomas F. Fuller

(a) RESIDENCE NO. 621 Harvey Street ST., 14 WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	child

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) 5/15/26

7 AGE	3 Years	Months	Days	If LESS than 1 day, hrs. or min.
		0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Thos F. Fuller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Della Serra

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Thos F. Fuller

(Address) 621 Harvey St

15 MAY 15 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 14, 1929, to May 15, 1929, that I last saw him alive on May 13, 1929, and that death occurred, on the date stated above, at 12 55 a. m.

The CAUSE OF DEATH* was as follows:

Intussusception with gangrene of ileum. Toxemia.

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of 5/14/29

Was there an autopsy? no

What test confirmed diagnosis? clinical and operation

(Signed) J. K. Gutch, M. D.

7/15, 1929 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkton

DATE OF BURIAL 5/17 1929

20 UNDERTAKER J. F. Schaub Sons

ADDRESS 318 Light St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 45984

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 33 E 45984

1-PLACE OF DEATH Women's Hospital

CITY OF BALTIMORE: (No. ..... St., 14-20 Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Burl Genevieve Jenkins

(a) RESIDENCE NO. Fairmont, W. Va. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 23 ds. How long in U. S., if of foreign birth? Life yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) August 6, 1903

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	25	8	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerical Worker

(b) General nature of industry, business, or establishment in which employed (or employer) Teaching High School

(c) Name of employer Supt. W. A. Hastad, Fairmont W. Va.

9 BIRTHPLACE (city or town) (State or country) Montclair, Co. Co. West Virginia

PARENTS

10 NAME OF FATHER Fred L. Jenkins

11 BIRTHPLACE OF FATHER (city or town) Upshur Co. (State or country) West Virginia

12 MAIDEN NAME OF MOTHER Clarissa Drummond

13 BIRTHPLACE OF MOTHER (city or town) Fort Wayne (State or country) Indiana

14 Informant Fred L. Jenkins (Address) Fairmont

15 Filed ..... 19 .....

C. HAMPSON JONES, M. D. Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1929

17 I HEREBY CERTIFY, That I attended deceased from Apr. 22. 1929. to May 15. 1929.

that I last saw her alive on May 15. 1929.

and that death occurred, on the date stated above, at 4 00 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of cecum and ileum.

(duration) yrs. 5 mos ..... ds.

CONTRIBUTORY (Secondary) Fecal fistula

(duration) yrs. 7 mos. 13 ds.

18 Where was disease contracted if not at place of death? Fairmont W. Va.

Did an operation precede death? Yes Date of Jan. 2. 1929

Was there an autopsy? Partial, yes.

What test confirmed diagnosis? Operation and autopsy

(Signed) Francis H. Langley, M. D.

19 (Address) Woman's Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Fairmont W. Va. DATE OF BURIAL May 17 1929

20 UNDERTAKER John O. Mitchell Sons ADDRESS 1400 Eutaw Place

MAY 15 1929

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

L 45985 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH.

44 E 45985

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1759 Gorsuch) ST., 9-4b WARD)

2-FULL NAME Jennie Holmes.

(a) RESIDENCE—NO. 1759 Gorsuch Av ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widowed

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of Late. William Holmes

6 DATE OF BIRTH (month, day, and year) Jan 27. 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	3	18.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Carrol County.

PARENTS

10 NAME OF FATHER Barney Hooker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md. Carrol County

12 MAIDEN NAME OF MOTHER Jemima Welch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Carrol County Md.

14 Informant Emma Sears.

(Address) 1759 Gorsuch ave.

Filed MAY 16 1929 H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1929

17 I HEREBY CERTIFY, That I attended deceased from June 16 1928 to May 15 1929

that I last saw h[illegible] alive on May 10 1929

and that death occurred, on the date stated above, at 2.15 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

(duration) ? yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary) Asthma

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) L. M. [illegible] M. D.

May 16, 1929 (Address) 1114 Hollins Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Grove. Chambersburg Pa.

DATE OF BURIAL: May. 18 1929

20 UNDERTAKER: D[illegible]

ADDRESS: L. Ruth 1735 Harford ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-12-23—M&T—500 Blks.

E 45986

HEALTH DEPARTMENT—CITY OF BALTIMORE E 45986

CERTIFICATE OF DEATH.

90

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3209. Taylor av St., 27-43 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertrude Wiechert

(a) RESIDENCE NO. 3209. Taylor av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE White

5 ~~Single, Married~~ or ~~Divorced~~, Widowed, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Henry Wiechert

6 DATE OF BIRTH (month, day, and year) Jan. 22 1856

7 AGE: Years 73 Months 3 Days 22 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework in

(b) General nature of industry, business, or establishment in which employed (or employer) own

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Geo. Hahn.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Catherine Hoffman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Catherine Wiechert

(Address) 3209. Taylor av Baltimore

15 MAY 16 1929 C. HAMILTON JONES, M. D. Physician

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1929

17 I HEREBY CERTIFY, That I attended deceased from April 30, 1929, to May 14, 1929

that I last saw h alive on May 13, 1929

and that death occurred, on the date stated above, at 5 45 a m

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Several Years

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis many years

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Morris B Grew, M. D.

5/15 1929 (Address) Hamilton Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemtry. DATE OF BURIAL May 18 1929.

20 UNDERTAKER Geo. J. Ruth ADDRESS 1735 Harford av.

Spec.—2-29-28—L. F. S.—500 Blks.

E 45987

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 45987

1—PLACE OF DEATH

REGISTERED NO. 24-33

CITY OF BALTIMORE: (No. So. Balto. Gen. Hosp. St., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Modres

(a) RESIDENCE NO. Sparrows Point. P.O. Box 87 St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. 19 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Dec 2, 1926

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	2	5	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER James Morris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greece

12 MAIDEN NAME OF MOTHER Virginia McCarthy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Greece

14 Informant Hospital Records

(Address)

15 Filed [illegible] 19 [illegible] C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/14/29

17

I HEREBY CERTIFY, That I attended deceased from 4/20, 1929, to 5/14, 1929.

that I last saw her alive on 5/14, 1929

and that death occurred, on the date stated above, at 10:05 p.m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Meningitis

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Unimportant.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home,

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Sp. Fluid

(Signed) T. Seton Wallace, M. D.

5/17, 1929 (Address) So. Balto. Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wood Lawn Cemtery. DATE OF BURIAL May 16 1929

20 UNDERTAKER Geo. F. Ruth ADDRESS 1735 Harford

MAY 16 1929

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10 21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45988

CERTIFICATE OF DEATH.

E 45988

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 311 N Franklin (St.) (Ward) 14-76

2-FULL NAME Susan E. Babylon

(a) RESIDENCE No. 311 N. Franklin ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 ~~Single, Married, Widowed,~~ or ~~Divorced,~~ (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Michael L. Babylon

6 DATE OF BIRTH (month, day, and year): Aug 31 1841

7 AGE: Years 85 | Months 8 | Days 15 | If LESS than 1 day, ... hrs or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Carroll Co md

PARENTS

10 NAME OF FATHER: Levy Hoagel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Carroll Co md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Charles H. Babylon (Address) 311 N. Franklin

15 Filed MAY 16 1929 19 H. McCOMAS JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 15th 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 5th, 1928, to May 15th, 1929.

that I last saw her alive on May 14th, 1929,

and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) C. A. Bamman, M. D.

May 15 1929 (Address) 724 Edmondson ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Frizellburg Md Co

DATE OF BURIAL: May 17 1929

20 UNDERTAKER: Sol Feinbloom & Son

ADDRESS: 2079 Pa

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 5099
E 45989

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

32 E 45989

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. 6-4 WARD)

2-FULL NAME Vernon Williams

(a) RESIDENCE NO. 709 N. Caroline St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced. (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6/14/25

7 AGE — Years: 3 — Months: 10 — Days: 29 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Lester

11 BIRTHPLACE OF FATHER (city or town) (State or country): N Car

12 MAIDEN NAME OF MOTHER: Jane Dennington

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

Filed MAY 16 1929, 19 C. HAMBY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1929

17 I HEREBY CERTIFY, That I attended deceased from May 7, 1929. to May 13, 1929, that I last saw him alive on May 13, 1929, and that death occurred, on the date stated above, at 5 30 A m.

The CAUSE OF DEATH* was as follows:

1. Tuberculous meningitis

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Spinal tap

(Signed) Dorothy O'Leary, M. D.

, 19 (Address) Johns Hopkins Hosp'l

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury cemetery, may 16 19 29 — DATE OF BURIAL

20 UNDERTAKER: Edward Bryan — ADDRESS 1691 orleans st

MARGIN RESERVED FOR BINDING

—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45990

CERTIFICATE OF DEATH.

9 E 45990

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 415 N. Durham ST. 6-9 WARD)

2-FULL NAME Henderson Scott.

(a) RESIDENCE NO. 415 N. Durham ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1925

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	4			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baby old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) S. Carolina

PARENTS

10 NAME OF FATHER Bonie Scott.

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. Carolina

12 MAIDEN NAME OF MOTHER Mary Bright.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. Carolina.

14 Informant Bonie Scott.

(Address) 415 N. Durham.

15 Filed MAY 16 1929 C. H. [illegible] JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 1929.

17 I HEREBY CERTIFY, That I attended deceased from May 13th 1929. to May 16. 1929

that I last saw h[illegible] alive on May 15. 1929.

and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Whooping Cough

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C. N. Pigott, M. D.

5/16 1929 (Address) 1536 W. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Old Bury cemetery — DATE OF BURIAL May 18, 29

20 UNDERTAKER Eden Bryan — ADDRESS 1631 Orleans St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45991

CERTIFICATE OF DEATH

90

E 45991

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 213 W Hoffman St. 11-24 Ward)

2-FULL NAME Charles F. Anderson

(a) RESIDENCE NO. 213 W Hoffman St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	Col	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
54	58			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Janitor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Chicago Ill
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Chas Nelson
(Address) 1130 W Lexington

15 Filed ..... 19 ..... C. HARRISON JONES, M. D.
Registrar

MAY 16 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) F. E. Leuck, M. D.

May 13th 1929 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL— Mt Olivet Cemetery — DATE OF BURIAL May 16, 1929

20 UNDERTAKER Mr Kate R. Williams & Schroeder — ADDRESS 322

Spec.–7-17-26—A Co.—200 Bks.

E 45992

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

75-00 E 45992

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1315 Stockton St. 16-23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lizzie Newman

(a) RESIDENCE NO. 1315 Stockton St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 10, 1880

7 AGE — Years: 49 Months: 4 Days: 4 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer

9 BIRTHPLACE (city or town): Richmond Co

(State or country): Va

PARENTS

10 NAME OF FATHER: Thomas H Newman

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Va

12 MAIDEN NAME OF MOTHER: Vinnie Taylor

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Va

14 Informant: Eddie Newman

(Address): 1315 Stockton St

MAY 16 1929

F. C. HAMPSON JONES, M. D. Registrar

Ref

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5-14-1929

17 I HEREBY CERTIFY, That I attended deceased from 5-13-, 1929, to 5-14-29, that I last saw h[illegible] alive on 5-14-, 1929 and that death occurred, on the date stated above, at 10:20 A.M.

The CAUSE OF DEATH* was as follows:

Hemiplegia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary): Acute Gastritis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? 1315 Stockton

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jno R Boykin M. D.

, 19 (Address) 1512 N. Gilmor

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery — Date of Burial: may 16 1929

20 UNDERTAKER: Thomas. E. Kelso — ADDRESS: 1345 Pennsylvania Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 45993

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 45993

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St. 4-30 Ward)

2-FULL NAME Wesley Hall Kyle

(a) RESIDENCE NO. Sierra Park, Md St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 25 - 1903.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	25	9	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Machinist
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER Frank D. Kyle

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Willa Hall

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant (Address) W. F. D. Kyle Sierra Park, Md

15 [illegible] HAMPSON JONES, M. D.
Registrar

MAY 19 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Crushing wound of chest

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Steamship Radiant

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edgar Zeller M. D.

5/16, 1929 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Annapolis Md	May 18 1929
20 UNDERTAKER	ADDRESS
Jas S. Taylor Sons	Annapolis Md

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45994

CERTIFICATE OF DEATH

E 45994

REGISTERED NO. 129

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 6118 Park Heights Ave (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Moses Daniel

(a) RESIDENCE NO. 6118 Park Heights Ave Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Fannie J. Daniel

6 DATE OF BIRTH (month, day, and year): Oct. 7, 1855

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
73	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Shoe

(b) General nature of industry, business, or establishment in which employed (or employer): Wholesaler 04

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Michael Daniel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant: Mrs. F. Daniel

(Address) 6118 Pk. Heights Ave

15 Filed MAY 16 1929 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/14/29.

17 I HEREBY CERTIFY, That I attended deceased from April, 1929, to May 14, 1929, that I last saw him alive on May 13, 29, 1929 and that death occurred, on the date stated above, at 8.30 P m.

The CAUSE OF DEATH* was as follows:

Anaemia

(duration) 10 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) 5 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Charles J Wells, M. D.

, 19 (Address) 5274 Park Heights Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Hebrew Cem	5/16/1929

20 UNDERTAKER: David Sondheim ADDRESS 115-20 W. Mt. Royal Ave

Spec.—6-9-19—H. P. Co.—1000 Bks.

45995 HEALTH DEPARTMENT—CITY OF BALTIMORE E 45995

CERTIFICATE OF DEATH. 24-001

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1730 Linden ave. St. H-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha Frey

(a) RESIDENCE. No. 1730 Linden ave ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female.	White.	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Isaac Frey.

6 DATE OF BIRTH (month, day, and year) 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none.

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Isaac

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Babette Stern

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

11 Informant Isaac Frey

(Address) 1730 Linden Ave.

Filed MAY 16 1929 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1929

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1929, to May 15, 1929, that I last saw h alive on May 15, 1929, and that death occurred, on the date stated above, at 9.55 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) 0 yrs. 0 mos. 6 ds.

CONTRIBUTORY (Secondary) Broncho - pneumonia

(duration) 0 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Examination

(Signed) Chas Mentzoldt, M. D.

, 19 (Address) 1730 Linden ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship Cem	5/17/ 1929

20 UNDERTAKER Harold Sondheim ADDRESS 18-20 W. Pratt. Royal

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45996

CERTIFICATE OF DEATH

E 45996

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 12-19 Ward)

2-FULL NAME Dr Alexander McFaul McMaster

(a) RESIDENCE NO. 1615 St Paul St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2½ yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Myrtle McMaster

6 DATE OF BIRTH (month, day, and year): Jan 7, 1859

7 AGE — Years: 70 Months: 4 Days: 7

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Physician

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Self.

9 BIRTHPLACE (city or town)

(State or country): Canada

PARENTS

10 NAME OF FATHER: David McMaster

11 BIRTHPLACE OF FATHER (City or town)

(State or country): U.S.

12 MAIDEN NAME OF MOTHER: Jane Carson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Richmond

14 Informant: Mrs Myrtle McMaster

(Address) 1615 St Paul St

15 Filed ..... 19 ..... Registrar

MAY 16 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/14/29 19

17 I HEREBY CERTIFY, That I attended deceased from 5/6/29, 19 ..... to 5/14/29, 19 .....

that I last saw him alive on 5/14/29, 19 .....

and that death occurred, on the date stated above, at 6:50 m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pancreas.

(duration) yrs 6 mos 10 ds.

CONTRIBUTORY (Secondary) Obstruction to Common Bile Duct

(duration) yrs 3 mos 3 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) J. S. Whitehead, M. D.

. 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: National Cem

Date of Burial: 5/16 19

20 UNDERTAKER: H. C. HAMILTON JONES, M. D.

ADDRESS 1217 E Fay

Spec.—1-10-21—M&T—1500 Bks.

222326

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45997

CERTIFICATE OF DEATH.

E 45997

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

2-FULL NAME Baby Vivian Scoby

(a) RESIDENCE No. 2915 Connec Ave Wash. D.C. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 9 1929 Unknown

7 AGE — Years: — Months: 3 Days: 6. If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Capt Wm Scoby

11 BIRTHPLACE OF FATHER (city or town) (State or country): ?

12 MAIDEN NAME OF MOTHER: Vivian ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Del

14 Informant: Records

(Address): JOHNS HOPKINS HOSPITAL

15 Filed MAY 16 1929 Registrar: H. M. JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb 9 1929 to May 15 1929,

that I last saw her alive on May 15 1929,

and that death occurred, on the date stated above, at 9 50 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Otitis media (R)-3 wks

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) F. C. Goodwin, M. D.

May 15 1929 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Arlington Cem Va

DATE OF BURIAL: May 16 1929

UNDERTAKER: John O Mitchell Sons

ADDRESS: 1908 Eutaw

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 45998

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 45998

REGISTERED NO. 11-2498

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 205 W Madison St., 11-24 Ward)

2-FULL NAME Jas F. Armstrong

(a) RESIDENCE NO. 205 W Madison St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Virginia B. Armstrong

6 DATE OF BIRTH (month, day, and year): Aug 18. 1852

7 AGE: Years 76 | Months 8 | Days 27 | IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Retire
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town): Md.
(State or country)

PARENTS

10 NAME OF FATHER: John B. Armstrong

11 BIRTHPLACE OF FATHER (city or town):
(State or country): Delaware

12 MAIDEN NAME OF MOTHER: Charlotte Boon

13 BIRTHPLACE OF MOTHER (city or town):
(State or country): Md

14 Informant (Address): Mrs V. B. Armstrong Shirley Grade

Filed MAY 16 1929 C. HAMPSON JONES, M.D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 15th 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) No F. C. Leuk, M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Park | DATE OF BURIAL May 17. 192

20 UNDERTAKER: John O. Mitchell & Sons | ADDRESS Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 45999

CERTIFICATE OF DEATH

X 74 E 45999

REGISTERED NO. .....

(If death occurred in a hospital or institution give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1610 Eutaw Place 4-20 St., ... Ward)

2-FULL NAME Paul Vaughan

(a) RESIDENCE No. High Park Mass St., Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Eliza S. Jare Married

6 DATE OF BIRTH (month, day, and year): July 19 1866

7 AGE: Years 62 Months 3 Days 25 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Outdoor Adviser
(b) General nature of industry, business, or establishment in which employed (or employer): 086
(c) Name of employer

9 BIRTHPLACE (city or town) Turkey
(State or country)

PARENTS

10 NAME OF FATHER Elias Vaughan

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) England

12 MAIDEN NAME OF MOTHER Marie —

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) England

14 Informant Paul Vaughan Jr.
(Address) St Summit St Boston

15 Filed ..... 19 HAMILTON JONES, M.D.

MAY 16 1925

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) May 14 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Apoplexy (duration) ..... yrs. Instd

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. .....

18 Where was disease contracted If not at place of death? No.

operation precede death? No. Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Regg

(Signed) Hamilton

May 15th 25 (Address) Coro

*State the Disease Causing Death, or in deaths state (1) Means and Nature of Injury, and Suicidal, or Homicidal. (See reverse side for

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loud

20 UNDERTAK

Spec.—12-9

6000

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

E 4600

REGISTERED NO.

1-PLACE OF DEATH Church Home + Inf. 2749

City of BALTIMORE: (No. Broadway + Fairmount St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Ethel Tweeddale

(a) RESIDENCE NO. Warrenton + Overhill Rds. Guilford Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female

4 Color or Race White

5 Single, Married, Widowed, or Divorced, (write the word) married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert D. Tweeddale

6 DATE OF BIRTH (month, day, and year) Dec 25. 1881

7 AGE Years 47 Months 4 Days 21 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work home duties

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) California

(State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Robert Dickson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Scotland

12 MAIDEN NAME OF MOTHER Jane Armstrong

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Canada

14 Informant Robert D. Tweeddale

(Address) Overhill + Warrington Rds

15 Filed 19 H. HARRISON JONES, M.D., Registrar

161929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15, 1929 19 29

17 I HEREBY CERTIFY, That I attended deceased from May 11, 19 29, to May 15, 19 29

that I last saw h.. alive on May 15, 19 29

and that death occurred, on the date stated above, at 3 P.M.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Walter B. Lehman, M. D.

May 1929 (Address) Church Home + Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Date of Burial May 16 29

20 UNDERTAKER J. Rob. Knuttel ADDRESS 5 W. Mt. Vernon Place

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 46001 5 E 46001

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1203 W Saratoga St. 18-16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Blanche Oleg.

(a) RESIDENCE NO. 1203 W Saratoga St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Fem.	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry P. Oleg.

6 DATE OF BIRTH (month, day, and year) Aug 6 1853

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	75	9	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Friendship N.Y.

(State or country)

PARENTS

10 NAME OF FATHER James T. Cameron

11 BIRTHPLACE OF FATHER (city or town)

(State or country) New York N.Y.

12 MAIDEN NAME OF MOTHER Mary Palmer Marshall

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) New York N.Y.

14 Informant Marie Wife

(Address) 1203 W Saratoga St.

Date MAY 16 1929 C. HAMILTON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

May 15 1929

17 I HEREBY CERTIFY, That I attended deceased from August, 1924 to May 15, 1929.

that I last saw h.. alive on May 15, 1929.

and that death occurred, on the date stated above, at 5:20 a.m.

The CAUSE OF DEATH* was as follows:

C.R. Valvular disease of Heart

(Mitral Insufficiency)

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) 5 yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) J.R. Thompson, M. D.

May 15, 1929 (Address) 1013 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

London Park May 1929

20 UNDERTAKER ADDRESS

John O. Mitchell & Sons 1401 Eutaw

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46002

CERTIFICATE OF DEATH

31 E 46002

34

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hospitals St. (E.B.) WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Adolph Escudero

(a) RESIDENCE NO. 1428 Gough st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Escudero

6 DATE OF BIRTH (month, day, and year) 1899

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	30			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Spain

PARENTS

10 NAME OF FATHER A. Escudero

11 BIRTHPLACE OF FATHER (city or town) (State or country) Spain

12 MAIDEN NAME OF MOTHER Marie Escudero

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Spain

14 Informant Hospital Records

(Address)

15 [illegible] Registrar

MAY 16 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13, 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan. 30, 1929, to May 13, 1929, that I last saw him alive on May 13, 1929 and that death occurred, on the date stated above, at 12.50 p. m.

The CAUSE OF DEATH* was as follows:

Caseous pneumonia

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical and autopsy

(Signed) Henry C. Smith, M. D.

5-13, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem	5/16/ 1929
20 UNDERTAKER	ADDRESS
J. J. Doherty Sons	1318 Light

IN RESERVED FOR [illegible]

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46003

REGISTERED NO. E 46003

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Balto City Hospital St. 12-50 Ward)

2-FULL NAME Martin Kennedy

(a) RESIDENCE NO. 331 Whitridge Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Mary A. Kennedy

6 DATE OF BIRTH (month, day, and year): April 21-1861

7 AGE: Years 68 | Months — | Days 24 | IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto.

PARENTS

10 NAME OF FATHER: Martin Kennedy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Ellen Rafferty

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Mary A. Kennedy 331 Whitridge Ave

Registrar

MAY 16 1929 HARRISON JONES

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 15 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis
Fracture femur
Fall down stairs
Hospital (duration) ... yrs. ... mos. 5 ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ~~331 Whitridge Ave~~

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Benton M. D.

5/16 1929 (Address) 700 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Joseph's Cem. Texas Md. DATE OF BURIAL 5/18 1929

20 UNDERTAKER: Chas. L. Evans & Son ADDRESS 1180 W. Mt. Royal Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46004 ✓ 118-802 E 46004

CERTIFICATE OF DEATH

E 46004 REGISTERED NO. 1124

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

1-PLACE OF DEATH

City of BALTIMORE: (No.) Maryland General Hospital St. Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick McElhone

(a) RESIDENCE NO. Upperville, Va. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~WIFE of~~ Rebecca McElhone

6 DATE OF BIRTH (month, day, and year) Dec 29-1879

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min..
	49	4	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer & Horse Breeder 886

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dist. of Columbia

PARENTS

10 NAME OF FATHER John McElhone

11 BIRTHPLACE OF FATHER (City or town) (State or country) Lila. Pa

12 MAIDEN NAME OF MOTHER Mary O'Harra

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14. Informant (Address) Hospital Records

15 Filed MAY 16 1929 16 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16. 1929

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1929, to May 16, 1929, that I last saw him alive on May 16, 1929, and that death occurred, on the date stated above, at 3:30 a m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction (Post operative) c

Local Peritonitis (duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary) Myocardial Failure

(duration) yrs. mos. 3 6 14 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? Yes Date of 5/10/29

Was there an autopsy? No

What confirmed diagnosis? Obstruction

(Signed) Thos Jackson Hooper M. D.

Address

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Upperville Va Date of Burial May 17 29

20 UNDERTAKER Harry W. Wizzle ADDRESS 1516 Lombard St

MAY 16 1929

Cor.—10-10-29—A Co.—100 Bks.

MARGIN RESERVED FOR BINDING

NB.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46005

E 46005

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1002 Plum Alley. St., 23-31 Ward)

2-FULL NAME Albert Wilson.(C)

(a) RESIDENCE NO. 1002 Plum Alley. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. ---- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Single.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	40	----------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Washington D.C.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Police Report. S.D.
(Address)

MAY 16 1929 19 E. HAMPSON JONES, M. D. Registrar

THE MORGUE.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 19, 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? History

(Signed) Otto U. Hantzsch, M. D.

5/14. 1929 (Address) 1917 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY.

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

MAY 16 192

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46006

E 46006

CERTIFICATE OF DEATH.

1-PLACE OF DEATH West Balto Genl Hosp REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., ... WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Fehl

(a) RESIDENCE No. 2905 Eastern Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

MARGIN RESERVED FOR BINDING

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) 5-14-29

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or ..... min.
			H	2

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) W. B. G. Hosp

PARENTS

10 NAME OF FATHER Chas. Fehl

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Henrietta Herman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant
(Address)

15 MAY 16 1929 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-14 1929

17 I HEREBY CERTIFY, That I attended deceased from 5-14, 1929 to 5-14, 1929

that I last saw h alive on ....., 19 .....

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Prematurity

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY
(Secondary) .....
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? NO Date of .....

Was there an autopsy? NO

What test confirmed diagnosis? .....

(Signed) Jack J. Singer, M. D.

, 19 (Address) West Balto. Gen'l Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: PUBLIC CEMETERY — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

Deputy Commissioner of Health. MAY 16 1929

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46007

CERTIFICATE OF DEATH

E 46007

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Pronounced dead at

City of Baltimore: (No.) Dald Ag Hospital 5-76

2-FULL NAME James Mattison

(a) RESIDENCE NO. 3330 Fairfield Road Ward Md

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAY 16 1929

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Mattison

6 DATE OF BIRTH (month, day, and year) Aug 31 1878

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
50	50	8	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer) Laborer 040
(c) Name of employer

9 BIRTHPLACE (city or town) X
(State or country) South Carolina

PARENTS

10 NAME OF FATHER J. Mattison

11 BIRTHPLACE OF FATHER (city or town)
(State or country) S C

12 MAIDEN NAME OF MOTHER Sarah Arnold

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) S C

14 Informant Sarah Mattison (wife)
(Address) 3330 Fairfield Rd. Md

15 C. HAMPSON JONES, M. D.
Registrar

Dist 0440

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 13 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Ruptured Appendix

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Pelvic Peritonitis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? 3330 Fairfield Road

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) James M Fenton M. D.

May 14 1929 (Address) 700 Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Calvary Cemetery	May 17 1929
20 UNDERTAKER	ADDRESS
Robert T Wilkins	1015 N Eutaw St

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 46008

REGISTERED NO.

E 46008

1-PLACE OF DEATH

CITY OF BALTIMORE: NO. 534 Poplar Grove ST. 20-10 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Francis Sullivan

(a) RESIDENCE. NO. 534 Poplar Grove ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs mos ds. How long in U. S., if of foreign birth? yrs mos ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marguerite Pfeffer Sullivan

6 DATE OF BIRTH (month, day, and year) June 6, 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	11	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Bakery

9 BIRTHPLACE (city or town) (State or country) Baltimore.

PARENTS

10 NAME OF FATHER John Sullivan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Boston Mass

12 MAIDEN NAME OF MOTHER Annie Sheehan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Boston Mass

14 Informant (Mrs. Jas. Sullivan) (Address) 534 Poplar Grove St

15 Filed MAY 16 1929 H. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1929

17 I HEREBY CERTIFY, That I attended deceased from April 2. 1929, to May 14. 1929.

that I last saw him alive on May 14. 1929. and that death occurred, on the date stated above, at 3.30 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Nephritis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? No.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Jos Michel M. D.

May 16 1929 (Address) 240 Cumberland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL

Cathedral Cemetery May 17, 29

ADDRESS

20 UNDERTAKER J. E. Flynn 1422 Light St

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation should be stated. See instructions on back of certificates. CERTIFICATION is very important.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46009

CERTIFICATE OF DEATH

E 46009

REGISTERED NO. 46

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1311 Hanover ST. 23-21 WARD)

2—FULL NAME Annie E. Eagan

(a) RESIDENCE NO. 1311 Hanover ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thos. J. Eagan

6 DATE OF BIRTH (month, day, and year): May 27, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	11	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Francis Bailey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Sarah Hatley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Miss Loretta Eagan

(Address) 1311 Hanover St

15 [illegible] 16 C. HAMPSON JONES, M. D. Registrar

MAY 16 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 14, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 13, 1929, to May 14, 1929, that I last saw h alive on May 14, 1929 and that death occurred, on the date stated above, at 11.06 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency
One Week.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Carcinoma - Breast

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) John A. Schenuit, M. D.

May 16, 1929 (Address) 1337 S Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: May 18 1929

20 UNDERTAKER: Marshall S. Flynn — ADDRESS: 1400 Light St

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46010

CERTIFICATE OF DEATH

E 46010

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Union Memorial Hospital ST. 12-49 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mr. William H. Stinson

(a) RESIDENCE NO. Howard, Howard Co, Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Wm H. Stinson

6 DATE OF BIRTH (month, day, and year) Jan. 19, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	3	28.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Howard Co., Md.
(State or country)

PARENTS

10 NAME OF FATHER Wm. H. Stinson

11 BIRTHPLACE OF FATHER (city or town) Scotland
(State or country)

12 MAIDEN NAME OF MOTHER Eugenia Warfield

13 BIRTHPLACE OF MOTHER (city or town) Howard Co, Md
(State or country)

14 Informant Pt. Hosp Records

(Address)

Filed MAY 17 1929 HAMPSON JONES, M. D. Registrar

DMF

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/16/29

17 I HEREBY CERTIFY, That I attended deceased from May 2d, 19 29, to May 16th, 19 29, that I last saw him alive on 5/16, 19 29, and that death occurred, on the date stated above, at 7:27 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Edwin J. C. Williams, M. D.

5/16 19 29 (Address) Union Memorial Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Howard Co. Oak Grove Cem

DATE OF BURIAL May 19 19 29

20 UNDERTAKER Easton Sons

ADDRESS Ellicott City

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46011 — **CERTIFICATE OF DEATH** — **X 117 E 46011**

1-PLACE OF DEATH Maryland General Hosp. REGISTERED NO.

City of BALTIMORE: (No. Howard & Madison St. 11-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Morris Frock

(a) RESIDENCE NO. Union Bridge, Md. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: July 30, 1879

6 DATE OF BIRTH (month, day, and year): unknown.

7 AGE: Years 55 Months 9 Days 17 IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer (Odd)

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Taneytown (State or country): Md

PARENTS

10 NAME OF FATHER: Albert Frock

11 BIRTHPLACE OF FATHER (City or town): (State or country): Md

12 MAIDEN NAME OF MOTHER: Fannie Staw

13 BIRTHPLACE OF MOTHER (city or town): (State or country): Md

14 Informant: Hosp. Record (Address)

15 Filed MAY 17 1929 Per C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 17 1929

17 I HEREBY CERTIFY, That I attended deceased from May 7, 1929, to May 17, 1929, that I last saw him alive on May 17, 1929, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Appendicial Abscess.

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary): Intestinal Obstruction

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of May 8.

Was there an autopsy? No

What test confirmed diagnosis? Operation & Autopsy

(Signed) H. H. Kerfoot, M. D.

5/17 1929 (Address) Md. Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Emmitsburg - Md — Date of Burial: May 19 1929

20 UNDERTAKER: C. D. Fuss & Son — ADDRESS: Taneytown Md

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Hks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46012

E 46012

CERTIFICATE OF DEATH

1—PLACE OF DEATH University Hosp. REGISTERED NO. 21-24

CITY OF BALTIMORE: (No. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Carrie Kestler.

(a) RESIDENCE NO. 806 Burgundy St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

6 If married, widowed, or divorced (or) WIFE of: Ernest Kestler

6 DATE OF BIRTH (month, day, and year): 7/1/1909

7 AGE: Years 19 yrs. Months 5 Days 14 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Jacob O. Bulgen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Mary E. Greiton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pennsylvania

14 Informant: Jacob O Bulgen

(Address) 806 Burgundy St

15 Filed: MAY 17 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 15th 1929.

17 I HEREBY CERTIFY, That I attended deceased from May 4th, 1929, to May 15th, 1929, that I last saw her alive on May 15th, 1929, and that death occurred, on the date stated above, at 8 P.m.

The CAUSE OF DEATH* was as follows:

Septicemia

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) (Streptococcus Viridans) Subacute bacterial endocarditis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? yes.

What test confirmed diagnosis?

(Signed) Eg Warner. M. D.

, 19 (Address) Univ. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery

DATE OF BURIAL: 5/18 1929

20 UNDERTAKER: William Cook

ADDRESS: 1217 St Paul St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46013

CERTIFICATE OF DEATH.

E 46013

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hosp (St.) H 25 (Ward) 100-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. John Lindsay

(a) RESIDENCE No. 634 Sara Ann ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M	Colored	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant

6 DATE OF BIRTH (month, day, and year): Feb 18 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	2	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant 000

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balt. Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Dorothy [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mother or administrator (Address)

15 MAY 17 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 14 1929

17 I HEREBY CERTIFY, That I attended deceased from May 9, 1929, to May 14, 1929, that I last saw him alive on May 14, 1929, and that death occurred, on the date stated above, at 3 45 p m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary): Premature Infant

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Undetermined

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) M. L. Jackson, M. D.

5/16 1929 (Address) 600 N. Arlington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: 5-17 1929

20 UNDERTAKER: Daniel Eaton & Co — ADDRESS: 5/16

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46014

REGISTERED NO. E 46014

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1425 Edmondson Ave St.) (WARD) 14-21

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John T. Taliaferro

(a) RESIDENCE NO. 1425 Edmondson Ave STREET WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ruth Taliaferro

6 DATE OF BIRTH (month, day, and year) 8-12-80

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48	9	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foster in Store

(b) General nature of industry, business, or establishment in which employed (or employer) Grocery Store

(c) Name of employer Corkery & Co.

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Wm. Allen Dale Taliaferro

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Fanny J. Talaferro

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Curtis Taliaferro

(Address) 1425 Edmondson

15 Filed MAY 17 1929 C. HARRISON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15-1929

17 I HEREBY CERTIFY, That I attended deceased from May 14th, 1929, to May 15th, 1929, that I last saw him alive on May 15th, 1929 and that death occurred, on the date stated above, at 3.40 P. m.

The CAUSE OF DEATH* was as follows:

Acute Gastritis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart (duration) yrs. mos. 2 days 145

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. E. Bell M. D.

5-16, 1929 (Address) 713 N. Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn DATE OF BURIAL May 17 1929

20 UNDERTAKER Wm. M. Howard & Son ADDRESS 4 W. Mosher

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. AGE should be carefully supplied. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46015

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46015

CERTIFICATE OF DEATH

REGISTERED NO. 91

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Mary's Home ST., 15-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lina E. Jean

(a) RESIDENCE NO. St Mary's Home ST., Gilmor & Pratt WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown 1849

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	80			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher 068

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Sister Susan [illegible] (Address) Gilmor & Pennsylvania

15 Filed MAY 17 1929 19 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16/29

17 I HEREBY CERTIFY, That I attended deceased from ~~Jan 1~~, 19~~29~~., to May 16 19 29

that I last saw h~~er~~ alive on May 15 19 29

and that death occurred, on the date stated above, at 1P m.

The CAUSE OF DEATH* was as follows:

Gen. Arteriosclerosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) L. L. McCourt M. D.

5/16. 1929 (Address) 2005 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery Woodlawn Cemetery

DATE OF BURIAL May 19 29

20 UNDERTAKER Clarence E. Wright ADDRESS 364 Mary

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. EACH ITEM MUST BE ANSWERED. mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

46016

CERTIFICATE OF DEATH

57

E 46016

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 833 N Eutaw ST. W-24 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Singleton Montell

(a) RESIDENCE NO. 833 N Eutaw ST. 11 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 5 mos. 11 ds. How long in U. S., if foreign birth? yrs. mos. ds.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

MAY 17 1929

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Jan 5 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
65	65	5	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired, Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER James E. Montell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Havana-New Providence

12 MAIDEN NAME OF MOTHER Elizabeth Singleton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Egbert S. Montell

(Address) 833 N. Eutaw St.

15 C. HAMPSON JONES, M. D.

Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16, 1929.

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1929, to May 16, 1929, that I last saw him alive on May 15, 1929, and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus

(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. C. Pelletier, M. D.

, 19 (Address) 817 Hamilton Ter.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mt Cem.

DATE OF BURIAL May 18th 1929

20 UNDERTAKER Henry H. Jenkins & Sons

ADDRESS Mc Culloh & Eutaw St.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46017 HEALTH DEPARTMENT—CITY OF BALTIMORE 129 E 46017

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 16-23

CITY OF BALTIMORE: (No.) 1101 W Lanvale (St.) (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Hamilton

(a) RESIDENCE NO. 1101 W Lanvale ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Hamilton

6 DATE OF BIRTH (month, day, and year) July 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
36	37	10	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lexington Va

PARENTS

10 NAME OF FATHER Samuel Hamilton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Cornelia Trail

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Elizabeth Hamilton (Address) 1101 W Lanvale St

15 Filed ..... G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May-16-29

17 I HEREBY CERTIFY, That I attended deceased from May 9, 1929, to May 16, 1929

that I last saw him alive on May 15, 1929

and that death occurred, on the date stated above, at 4.45 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis + Arteriosclerosis (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) A. K. Hughes, M. D.

5/16, 1929 (Address) 825 N. Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lynchburg Va — DATE OF BURIAL 5/18/29

20 UNDERTAKER Samuel Kemsley — ADDRESS 1118 N Bridle

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 46018 HEALTH DEPARTMENT—CITY OF BALTIMORE E 46018

CERTIFICATE OF DEATH.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 678 Biddle ST. 17-24 WARD)

2-FULL NAME Francisco Lorenzo

(a) RESIDENCE NO. 678 W. Biddle ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. ..... mos. ..... ds. How long in U. S., If of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of - (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1869

7 AGE: Years 60 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Private

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Ft. Mary Co. Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Mrs. Theresa Timmons 678 W. Biddle St.

15 Filed MAY 1 1929, 19 ..... Registrar C. HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): April 16 1929

17 I HEREBY CERTIFY, That I attended deceased from April 9, 1929, to April 16, 1929, that I last saw h alive on April 16, 1929, and that death occurred, on the date stated above, at 9 A.M. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 4 mos 7 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Symptoms

(Signed) H. Lee Ellis M. D.

(Address) 924 North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Peters Cem. DATE OF BURIAL May 1 1929

20 UNDERTAKER: Samuel Hensley Jr. ADDRESS 518 Biddle

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46019

CERTIFICATE OF DEATH

24-001

E 46019

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1920 Mc Culloh St. 14-20 Ward)

2-FULL NAME Thos. H. Lee

(a) RESIDENCE NO. 1920 Mc Culloh St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 10 mos. 7 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Julia Lee,

6 DATE OF BIRTH (month, day, and year): July 7-1878

7 AGE: Years 50 | Months 10 | Days 7 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Driver.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) Balto Md.
(State or country)

PARENTS

10 NAME OF FATHER John Lee

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Sarah Lee,

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant: Julia Lee
(Address) 1920 Mc Culloh

15 Filed ....., 19.... C. HARRISON JONES, M. D., Registrar.

By .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to Sudden death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Apoplexy) (duration) ..... yrs. ..... mos. Sudden ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Regular

(Signed) H. C. Jones, M. D.

19 May 14 1929 (Address) Coroner.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	May 18 29

20 UNDERTAKER: Edward L. Kennedy ADDRESS 1128 Bank St.

MAY 17 1929

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46020

CERTIFICATE OF DEATH

24 E 46020

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital ST. 15-68 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna Brack

(a) RESIDENCE NO. 2731 W North Ave ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 21 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	1	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housemaid

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer Mrs Ludmont

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Albert Brack

11 BIRTHPLACE OF FATHER (city or town) (State or country) France Italy

12 MAIDEN NAME OF MOTHER Wilhelmina

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs E Downes

(Address) 2731 W North Ave

15 Filed MAY 17 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 11, 1929 to May 15, 1929 that I last saw her alive on May 15, 1929 and that death occurred, on the date stated above, at 9 50 A. m.

The CAUSE OF DEATH* was as follows:

Meningitis (meningococcal)

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 2731 W. North Ave

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Addison Craft M.D. M. D.

5-16, 1929 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Sanitary

DATE OF BURIAL May 17 1929

20 UNDERTAKER Jeremiah Dwyer

ADDRESS 1119 Hartte

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46021 — 74-801 — E 46021

CERTIFICATE OF DEATH

REGISTERED NO. ____

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 822 S. Paca ST. 21-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Strohmann

(a) RESIDENCE NO. 822 S. Paca ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if foreign birth? 73 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6 If married, widowed, or divorced — HUSBAND of (or) WIFE of: George W. Strohmann

6 DATE OF BIRTH (month, day, and year): Apr. 6, 1848

7 AGE — Years: 81 — Months: 1 — Days: 9 — If LESS than 1 day, ____ hrs. or ____ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Louis Schmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. Louise Strohmann

(Address) 822 S. Paca St

15 Filed MAY 17 1929 H. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 15 1929

17 I HEREBY CERTIFY, That I attended deceased from April 8, 1929, to May 15, 1929, that I last saw h alive on May 15, 1929 and that death occurred, on the date stated above, at 12 P m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary): Pulmonary Oedema

(duration) 1 yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) S. E. Buxton, M. D.

5/16, 1929 (Address) 301 E. Cross

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: May 20 1929

20 UNDERTAKER: Wm. Hickner & Sons — ADDRESS: North & Pa

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46022

CERTIFICATE OF DEATH

REGISTERED NO. E 46022

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2122 Bolton ST. 13-54 WARD)

2—FULL NAME Mary Colladay Burgess

(a) RESIDENCE NO. 2122 Bolton ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 85 yrs. mos. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles R Burgess

6 DATE OF BIRTH (month, day, and year): June 6-1843

7 AGE: Years 85 Months 11 Days 9 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Joseph S. Colladay

11 BIRTHPLACE OF FATHER (city or town) (State or country): Phila. Penna.

12 MAIDEN NAME OF MOTHER: Mary Mason

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

11 Informant: Ida C. Burgess

(Address) 4208 Parkside ave

Filed MAY 17 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 15-1929

17 I HEREBY CERTIFY, That I attended deceased from Feb. 10, 1929, to May 15, 1929, that I last saw h alive on April 24, 1929, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at 527 N. Carrollton Ave

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical signs and symptoms

(Signed) Chas. Leaf, M. D.

May 16, 1929 (Address) 1111 W. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: May 17 1929

UNDERTAKER: Chas. J. Tschudi

ADDRESS: Mount Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46023

CERTIFICATE OF DEATH

90

E 46023

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 113 London Ave ST. 20-1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Florence M. Addison

(a) RESIDENCE NO. 113 London Ave ST.

(Usual place of abode) WARD

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 28, 1858

7 AGE — Years: 70 — Months: 9 — Days: 18 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): School teacher

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Geo. C. Addison

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Marietta Bond

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: J. Addison Albaugh

(Address) Randallstown

15 Filed MAY 17 1929 19 H. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 16-1929

17 I HEREBY CERTIFY, That I attended deceased from May 2, 1929, to May 16, 1929

that I last saw her alive on May 16, 1929

and that death occurred, on the date stated above, at 1.09 m.

The CAUSE OF DEATH* was as follows:

Hypertension

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac decompensation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Cl + Phy Exam

(Signed) Fred T. Kuhnen, M. D.

19 (Address) 3321 Frederick Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount

DATE OF BURIAL: May 18 19 29

20 UNDERTAKER: Wm. J. Tuckner & Sons

ADDRESS: N. & Pa.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46024 CERTIFICATE OF DEATH 90 E 46024

1—PLACE OF DEATH REGISTERED NO.

CITY OF BALTIMORE: (No. 1732 W. North ST. 15-21 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie Marie Boyle

(a) RESIDENCE NO. 1732 W North Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): about May 7 1868

7 AGE: Years 61 | Months 0 | Days 9 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Laurence Boyle

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Elizabeth Bolton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs Mollie Bayer Sister (Address) 1732 W North Ave

15 [illegible] C. HARRISON JONES, M. D. Registrar

MAY 17 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 6 29

17 I HEREBY CERTIFY, That I attended deceased from April 28th, 19 29, to May 6th, 19 29, that I last saw h[illegible] alive on May 5 — 19 29 and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(duration) 2 yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Catarrhal Pneumonia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Samuel A Bayer, M. D.

19 (Address) 1420 Fallsway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL; CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	May 29 19 29
D. UNDERTAKER	ADDRESS
Stewart & Co	Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

86-001

E 46025

CERTIFICATE OF DEATH

E 46025

1—PLACE OF DEATH University Hospital

REGISTERED NO. ....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Lombard & Greene St. ST. 27-53 WARD)

2—FULL NAME J. Rogers * Swindell Jr.

(a) RESIDENCE NO. 603 Club Road, Roland Park ST.. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. 10 mos. 8 ds. How long in U. S., if foreign birth 40 yrs. 10 mos. 8 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Wilson Swindell

6 DATE OF BIRTH (month, day, and year) July-8-1888

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	40	10	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Commission Merch't

(b) General nature of industry, business, or establishment in which employed (or employer) Swindell Bros

(c) Name of employer Glass Mfrs.

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER J. Rogers Swindell

11 BIRTHPLACE OF FATHER (city or town) Balto
(State or country) Md.

12 MAIDEN NAME OF MOTHER Elyssia Kahler

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant Mrs Mary W. Swindell (wife)
(Address) 603 Club Road

15 Filed MAY 17 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-16-29

17

I HEREBY CERTIFY, That I attended deceased from May 9th, 1929, to May 16, 1929, that I last saw him alive on May 16, 1929 and that death occurred, on the date stated above, at 6.50 A m.

The CAUSE OF DEATH* was as follows:

Pneumococcus Meningitis, Type IV

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Right Mastoiditis (Chronic)

& R.L. Otitis Media (duration) yrs. 1½ mos. ds.

18 Where was disease contracted if not at place of death? ....

Did an operation precede death? Yes Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? Spinal puncture with Culture [illegible]

(Signed) M. Abbott, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	May 18 1929
20 UNDERTAKER	ADDRESS
Stewart & Co	Balto.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46026 HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

CERTIFICATE OF DEATH

E 46026

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1529 Park Av, ST., 1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frances Louise Stevens

(a) RESIDENCE NO. 1529 Park Av ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. 6 mos. 0 ds. How long in U. S., if foreign birth 61 yrs. 6 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Nov - 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61	6	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Teacher

(b) General nature of industry, business, or establishment in which employed (or employer): Public Schools

(c) Name of employer: City of Baltimore

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: John W. Stevens

11 BIRTHPLACE OF FATHER (city or town) (State or country): L. A. Co. Maryland

12 MAIDEN NAME OF MOTHER: Sarah Emory

13 BIRTHPLACE OF MOTHER (city or town) (State or country): L. A. Co. Maryland

14 Informant: Dr. J. K. B. E. Seegar Cousin

(Address): 325 Stockholm Rd

15 Filed MAY 17 1929 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 15th 1929

17

I HEREBY CERTIFY, That I attended deceased from May 8th, 1929, to May 15th, 1929, that I last saw h[illegible] alive on May 15th, 1929 and that death occurred, on the date stated above, at 8. P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia (over)

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Respiratory - Cardiac failure

serval bowel (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Exam by stethoscope

(Signed) J. Kemp B E Seegar, M. D.

, 19 (Address) 904 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery — DATE OF BURIAL: May 17/29.

20 UNDERTAKER: Stewart & Mercer Co — ADDRESS: Balto.

B.—WRITE PLAINLY, WITH INDELIBLE PENCIL. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46027 HEALTH DEPARTMENT—CITY OF BALTIMORE E 46027

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 829 N. Montford Ave ST., 12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sylvester Stiegler Jr.

(a) RESIDENCE NO. 829 N. Montford Ave. (Usual place of abode) WARD

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S. if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Josephine Stiegler

6 DATE OF BIRTH (month, day, and year) April 1 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	1	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Czecho-Slovakia

PARENTS

10 NAME OF FATHER Sylvester Stiegler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Czecho-Slovakia

12 MAIDEN NAME OF MOTHER Elisabeth Svec

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Czecho-Slovakia

14 Informant Josephine Stiegler (Address) 829 N. Montford Ave

15 Filed MAY 17 1929, 19 HAMPSON JONES, M. D. Registrar Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1927 to May 16 1929

that I last saw h~~e~~r alive on May 16 1929

and that death occurred, on the date stated above, at 3-10 P. M.

The CAUSE OF DEATH* was as follows:

Lingering Lectoris

(duration) 2 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Vincent E. Koska, M. D.

19 (Address) 845 N. Pod. P.K. Co

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Hill Cemetery	May 20 1929

20 UNDERTAKER August Pasch ADDRESS 2406 Ashland Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. The information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46028

CERTIFICATE OF DEATH

129 E 46028

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1027 Russell St. 21-31 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Hoffman

(a) RESIDENCE NO. 1027 Russell St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret

6 DATE OF BIRTH (month, day, and year): Oct 12 1876

7 AGE: Years 53 Months 7 Days 3 IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer): 015

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto.

PARENTS

10 NAME OF FATHER: William

11 BIRTHPLACE OF FATHER (City or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Elizabeth Keyser

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto.

14 Informant: John Hoffman

(Address) 1027 Russell St

MAY 17 1929 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: May 15th 1929

17 I HEREBY CERTIFY, That I attended deceased from May —, 1929, to May 15, 1929

that I last saw him alive on May 15, 1929

and that death occurred, on the date stated above, at 12 30 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John Shearer Worthington M. D.

5-16-29 (Address) 642 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Cem. Date of Burial: May 18 1929

20 UNDERTAKER: M. W. & H. Deppe ADDRESS: Box 37 Station A

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

E 46029

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46029

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2922 Boarman Ave. ST. 15-58 WARD)

2-FULL NAME Caroline Elizabeth Easter. —

(a) RESIDENCE NO. 2922 Boarman Ave. — ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White.	Widowed. —

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Geo. Washington Easter.

6 DATE OF BIRTH (month, day, and year) June 4 1865.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	11	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany —

PARENTS

10 NAME OF FATHER ? Strelley —

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Mrs. Clarence Inman

(Address) 4302 Forest View Ave

15 MAY 17 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/15 1929

17 I HEREBY CERTIFY, That I attended deceased from 5/12, 1929, to 5/15, 1929, that I last saw h[illegible] alive on 5/15, 1929, and that death occurred, on the date stated above, at 10:10 P. m.

The CAUSE OF DEATH* was as follows:

Arterio-Sclerosis & Chr. Myocarditis

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Chas. Cirlan Stewart, M. D.

5/16, 1929 (Address) 1738 E. 22nd St. —

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: May 18 1929

20 UNDERTAKER: Frederick Loudenslager — ADDRESS: Fullerton

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Ahern

E 46030

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

48 ✓

E 46030

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 950 Hollins ST. 18-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Cornelius Ahern

(a) RESIDENCE NO. 950 Hollins ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred ~~5 yrs.~~ life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Blanche Ahern

6 DATE OF BIRTH (month, day, and year) Dec 15, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work restaurant keeper

(b) General nature of industry, business, or establishment in which employed (or employer) Ostd

(c) Name of employer Self

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Michael Ahern

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Blanche Ahern

(Address) 1735 Hollins St

15 Filed MAY 17 1929, 19 HAMILTON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1927, to May 15, 1929, that I last saw him alive on May 14, 1929 and that death occurred, on the date stated above, at 10.30 P. m.

The CAUSE OF DEATH* was as follows:

Epithelioma of the face

over 2 yrs (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) none

(duration) — yrs mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical tests

(Signed) Henry C. Ahle M. D.

5-16, 1929 (Address) 1203 W. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	May 18 1929
20 UNDERTAKER George J. Smith	ADDRESS 1532 Hollins

18.—WRITE PLAINLY, WITH UNFADING INK. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46031

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46031

REGISTERED NO.

1—PLACE OF DEATH St Joseph's Hospital

CITY OF BALTIMORE: (No. Caulins & Olives ST. 10-12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Anna M. Sebald

(a) RESIDENCE NO. 1019 Somerset St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. 7 mos. 19 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK. This is a Permanent Record. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John L. Sebald

6 DATE OF BIRTH (month, day, and year) Sept. 27 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or mln.
	54	7	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John H. Bornhorn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Philimina Albert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr John L. Sebald.

(Address) 1019 Somerset St

15 Filed MAY 17 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 1929

17 I HEREBY CERTIFY, That I attended deceased from 5/15/29, 19, to 5/16/29, 19, that I last saw her alive on 5/15/29, 19 and that death occurred, on the date stated above, at 5.15 A m.

The CAUSE OF DEATH* was as follows:

Diabetes

(duration) Four Months ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) V. Messina, M. D.

, 19 29 (Address) St. Joseph's Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL May 20 1929

20 UNDERTAKER Henry Hoen's Sons Inc. — ADDRESS 1301 E Eager St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46032

CERTIFICATE OF DEATH

65-001

E 46032

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1204 N. Bond ST., 7-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mr. Elizabeth Stewart

(a) RESIDENCE NO. 1204 N. Bond ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 8 mos. 22 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of: Robert P. Stewart

6 DATE OF BIRTH (month, day, and year): Aug. 23 1859

7 AGE: Years 69 | Months 8 | Days 22 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Michael Parr

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary E. Bitner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mr Robert P. Stewart

(Address) 1204 N. Bond St

15 Filed MAY 17 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 15th 1929

17 I HEREBY CERTIFY, That I attended deceased from October, 1927, to May 15, 1929.

that I last saw her alive on May 12 1929

and that death occurred, on the date stated above, at 12 10 P. m.

The CAUSE OF DEATH* was as follows:

Organic Heart disease

(duration) 1 yrs. 8 mos. ds.

CONTRIBUTORY (Secondary): Hyperthyroidism

(duration) 1 yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

5/15, 1929 (Signed) Jos J Kinzer, M. D.

(Address) 2700 Harford Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: May 18 1929

20 UNDERTAKER: Henry Hoeck Sons, Inc. — ADDRESS: 1301 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46033 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 ✓ E 46033

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Josephs Ho ST., WARD 26-28

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna B. Hall

(a) RESIDENCE NO. 33rd St & Hamilton Ave WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if foreign birth? Life mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND~~ (or) WIFE of Albert H. Hall

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	44	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 07

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Robert Roth.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs. Albert H. Hall

(Address) 33rd & Hamilton Ave

15 Filed MAY 17 1929 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/17/29

17 I HEREBY CERTIFY, That I attended deceased from 5/13, 1929, to 5/17/29, 19..., that I last saw h... alive on 5/17/29, 19..., and that death occurred, on the date stated above, at 6 30 a m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Myocarditis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Decompensation & general anasarca (duration) ... yrs. 2 mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. Eccleston, M. D.

5/17, 1929 (Address) St Josephs Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	May 20 19 29
20 UNDERTAKER	ADDRESS
Henry Hoen & Sons Inc.	1301 E Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK. THE INFORMATION SHOULD BE STATED EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46034

CERTIFICATE OF DEATH

E 46034

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 937 N. Calvert ST. 11-15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emma Lillian Mowers

(a) RESIDENCE NO. 150 W. Orange ST., Shippensburg, Penn. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. 8 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles E. Mowers

6 DATE OF BIRTH (month, day, and year) Jan. 15, 1870.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	59	4	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in whirh employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Shippensburg, Penn

PARENTS

10 NAME OF FATHER Harry Brenneman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn.

12 MAIDEN NAME OF MOTHER Adeline Shuman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Penn.

11 Informant Charles E. Mowers

(Address) 150 W. Orange St. Penn

15 Filed MAY 17 1929 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17th, 1929.

17

I HEREBY CERTIFY, That I attended deceased from May 9th, 1929, to May 16th, 1929, that I last saw h-er alive on May 16th, 1929, and that death occurred, on the date stated above, at 6.10 A. m.

The CAUSE OF DEATH* was as follows:

Primary carcinoma of liver; metastatic deposits in intestines and omentum.

(duration) One — mos. — ds.

CONTRIBUTORY (Secondary) Myocardial insufficiency,

(duration) — — — ½ ds.

18 Where was disease contracted if not at place of death? Shippensburg, Pa.

Did an operation precede death? no. Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Clinical.

(Signed) C. W. G. Rohrer, M. D.

. 19 (Address) 2814 Ailsa Ave., Balto. Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Shippensburg, Penn.

DATE OF BURIAL 5/17 1929

20 UNDERTAKER Henry W. Myers and Son

ADDRESS 805 N. Calvert St.

N. B.—WRITE PLAINLY, WITH LEAD PENCIL. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46035

161-001

E 46035

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2552 McCulloh ST. 13-54 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Girl Boston # 1

(a) RESIDENCE NO. 2552 McCulloh ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred — yrs. — mos. — ds. — How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Black	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 15, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balt. Md.

PARENTS

10 NAME OF FATHER Joseph Alexander Boston

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cambridge Md.

12 MAIDEN NAME OF MOTHER Annie Ann Mooney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Eastern Shore Md.

14 Informant Joseph Alexander Boston
(Address) 2552 McCulloh St.

15 Filed ..., 19 ... Registrar

MAY 1 1 1929 HARRISON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1929 to May 15, 1929 that I last saw h[illegible] alive on May 15, 1929 and that death occurred, on the date stated above, at 5 00 p. m.

The CAUSE OF DEATH* was as follows:

~~Premature Birth~~

Prematurity.

— (duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) ~~Prematurity~~

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? none

(Signed) W. Alexander Worley M. D.

, 19 (Address) 1516 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL ... 19

20 UNDERTAKER — ADDRESS

JOHNS HOPKINS HOSPITAL MAY 16 1929

N. B.—WRITE PLAINLY, WITH UNFADING INK. This information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001

E 46036 CERTIFICATE OF DEATH E 46036

1—PLACE OF DEATH

REGISTERED NO. 13-29

CITY OF BALTIMORE: (No. 2552 McCulloh ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Girl Boston ~~#~~

(a) RESIDENCE NO. 2552 McCulloh ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred _ yrs. _ mos. _ ds. _ How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Black	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
—	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balt. Md.

PARENTS

10 NAME OF FATHER Joseph Alexander Boston

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cambridge, Md

12 MAIDEN NAME OF MOTHER Annie Ann Mooney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Eastern Shore, Md

14 Informant Joseph Alexander Boston
(Address) 2552 McCulloh St.

15 Filed MAY 17 1929 WILLIAM H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1929, to May 15, 1929, that I last saw her alive on May 15, 1929 and that death occurred, on the date stated above, at 11 30 a. m.

The CAUSE OF DEATH* was as follows:

~~Cardiac failure~~
Prematurity

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) ~~Pneumonia~~

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. Alexander Morey, M. D.

, 19 (Address) 1516 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

JOHNS HOPKINS HOSPITAL MAY 16 1929

N. B.—WRITE PLAINLY, WITH UNFADING INK. ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46037

CERTIFICATE OF DEATH

E 46037

100-00

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. President Apt 16-16 St. Ward)

2-FULL NAME Sterling F Moore

(a) RESIDENCE NO. 1310 Edmondson Av. Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 1 mos. 29 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Mal	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of No

6 DATE OF BIRTH (month, day, and year) Mar 17-1928

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	1	1	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None, Inf
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Percy Wright.

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Bernice Moore

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Lucy Moore
(Address) 1310 Edmondson Av

15 Filed MAY 17 1929 16 C. HARRY JONES M. D. Registrar

17 Burial Permit Issued 1644

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an .....
(Inquest, autopsy or inquiry)
thereon and from the evidence obtained by said Autopsy & Inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia
(Duration) ..... yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary) Otis Media
(duration) ..... yrs. ..... mos. 5 ds.

18 Where was disease contracted if not at place of death? 1310 Edmondson Av

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Regular

(Signed) May 16 1929 (Address) C. F. Leith, M. D. Coroner

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	May 17 1929

20 UNDERTAKER Wm George E. Collins ADDRESS 1631 Druid Hill

MARGIN RESERVED FOR BINDING

R—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46038

CERTIFICATE OF DEATH

44

REGISTERED NO.

1. PLACE OF DEATH

City of BALTIMORE: (No. 1008 Vincent St., 16-22 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Mullen

(a) RESIDENCE NO. 1008 Vincent St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred | yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
female	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Mullen

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
	56	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) 639

(c) Name of employer Self

9 BIRTHPLACE (city or town) Anarundal Co. Md

(State or country)

PARENTS

10 NAME OF FATHER Charles Brown

11 BIRTHPLACE OF FATHER (City or town) Anarundal Co Md

(State or country)

12 MAIDEN NAME OF MOTHER Annie Powell

13 BIRTHPLACE OF MOTHER (city or town) Anarundal Co.

(State or country)

14 Informant Marie Mullen

(Address) 350 Calhoun St.

C. HAMPSON JONES, M. D.

Registrar

MAY 17 1929

Pat

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-16 1929

17 I HEREBY CERTIFY, That I attended deceased from 5-11-, 1929, to 5-16-, 1929, that I last saw her alive on 5-16, 1929, and that death occurred, on the date stated above, at 9:15 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown

Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Appearance

(Signed) Frank L Saunders M. D.

5-17-1929 (Address) 1029 N. Stricker St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Carlen's Chapel G.A.B. Date of Burial May 18 1929

20 UNDERTAKER [redacted] ADDRESS A. Brotko 1463 N. Carey

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46039

CERTIFICATE OF DEATH.

151 E 46039

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2007. E Biddle St. (WARD) 8-17

2-FULL NAME Harand. a. Jones.

(a) RESIDENCE No. 2007. E Biddle ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lillian Jones.

6 DATE OF BIRTH (month, day, and year): April 5 1891

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	38	1	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman 66

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Empire Laundry.

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: H. W. Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Ada Brown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: L. John. (Address) 2007. E. Biddle St.

15 Filed ... 19... C. HAMPSON JONES, M. D. Registrar

MAY 17 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 15 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec. 14, 1927, to May 15, 1929.

that I last saw h[illegible] alive on " 14, 1929

and that death occurred, on the date stated above, at 8 a m

The CAUSE OF DEATH* was as follows:

Raynaud's Disease

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary): Cardiac failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of Jan 28

Was there an autopsy? no Rumors Jones.

What test confirmed diagnosis? Physical signs

(Signed) Chas. S. Kees M. D.

5/15/29 (Address) 405 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore County.

DATE OF BURIAL: May 18 1929.

20 UNDERTAKER: Geo. F. Rutt

ADDRESS: 1735 Hoffard Ave

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item and information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46040

CERTIFICATE OF DEATH

31 E 46040

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 355 S. Bentalou St. W-69 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lizzie Carrieri

(a) RESIDENCE NO. 355 S. Bentalou St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Dominick Carrieri

6 DATE OF BIRTH (month, day, and year) Nov 24 1870

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	58 yrs	5	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Italy

(State or country)

PARENTS

10 NAME OF FATHER Dominick Polazardo

11 BIRTHPLACE OF FATHER (City or town) Italy

(State or country)

12 MAIDEN NAME OF MOTHER Concetta Dantonio

13 BIRTHPLACE OF MOTHER (city or town) Italy

(State or country)

14 Informant Salvador Polazardo

(Address) 2324 Carrollton ave

15 Filed C. HAMPSON JONES, M. D. Registrar

Par

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15th 1929.

17 I HEREBY CERTIFY, That I attended deceased from Nov 15, 1928, to May 15, 1929, that I last saw h alive on May 15, 1929, and that death occurred, on the date stated above, at 6.30 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis, Diabetes

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Michael A Abrahms, M. D.

5-17-1929. (Address) 360 Eutaw place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

New Cathedral Cemetery May. 20 1929.

20 UNDERTAKER — ADDRESS

Charles J. Schwab 505 N Monroe St.

MAY 17 1929

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

2 E 46041 HEALTH DEPARTMENT—CITY OF BALTIMORE E 46041

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

2-FULL NAME Shannan Gamble

(a) RESIDENCE NO. Chattanooga ST., Tenn — WARD —
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divoreed HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 2, 1923

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
6	—	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Tenn —

PARENTS

10 NAME OF FATHER Shannan Gamble

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ga —

12 MAIDEN NAME OF MOTHER Essie Roberts

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ala.

14 Informant: Reeds. (Address) JOHNS HOPKINS HOSPITAL

15 MAY 17 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1929

17 I HEREBY CERTIFY, That I attended deceased from May 9, 1929, to May 17, 1929, that I last saw him alive on May 17, 1929, and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Malignant Brain Tumor

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Tetany

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation preeede death? yes Date of May 4, 1929

Was there an autopsy? yes.

What test confirmed diagnosis? Operation

(Signed) Fred W Bert, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Aeeidental, Suieidal, or Homieidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Piedmont, Alabama — DATE OF BURIAL: May 17 1929

20 UNDERTAKER: John Mitchell & Son — ADDRESS: Eutaw St.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 46042

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 46042

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5113 Whiteford Ave (Govans) St.) 27-18 (WARD) 90

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Wilson Hogg

(a) RESIDENCE No. 5113 Whiteford Ave ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	widowed

5a If married, widowed, ~~divorced~~
(or) WIFE of John Kunkel Hogg

6 DATE OF BIRTH (month, day, and year) May 21.1846

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	82	11	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER George Meyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Augusta Stoffregen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Minna Benny
(Address) 5113 Whiteford Ave

15 MAY 17 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15. 1929

17 I HEREBY CERTIFY, That I attended deceased from June 1925 to May 15 1929 that I last saw her alive on May 13th 1929 and that death occurred, on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH* was as follows:

Primary Arterio Sclerosis

(duration) 4 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physician & Clinical

(Signed) Gustav Goldman, M. D.

, 19 (Address) 1516 W Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Frederick, Md. DATE OF BURIAL May 18-29

20 UNDERTAKER Hughes & Jones Inc ADDRESS 424 N. Bridy

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Dr Lennon ✓ 4184 Old Park Ave 3123 Eastlake

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46043

CERTIFICATE OF DEATH

101-001 E 46043

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1821 E 33rd ST. 9-46 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Conrad Lautenklos

(a) RESIDENCE NO. 1821 E 33rd ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6 DATE OF BIRTH (month, day, and year): Dec 16 1876

7 AGE — Years: 52 — Months: 6 — Days: — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer): Ob

(c) Name of employer: C Hohmon & Sons

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Peter Lautenklos

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Barbara Amrhein

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Helene Lautenklos

(Address) 1821 E 33rd St

15 Filed MAY 17 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 16 1929

17 I HEREBY CERTIFY, That I attended deceased from May 11, 1929, to May 16, 1929, that I last saw h alive on May 16, 1929, and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

(duration) yrs. mos. 2 Ds

CONTRIBUTORY (Secondary): T. Latus Pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edwd H Lennon, M. D.

5/17, 1929 (Address) 918 N Patterson Pk Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore — DATE OF BURIAL: 5/18 1929

20 UNDERTAKER: H. Cook — ADDRESS: 1217 E Pratt St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

Spec. -7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46044

CERTIFICATE OF DEATH

49

E 46044

REGISTERED NO.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item in this section should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 2826 Winchester St. (Ward) 16-68

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ella Gill

(a) RESIDENCE NO. 2826 Winchester St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: white

5 Single, Married, Widowed, or Divorced. (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 1st 1877

7 AGE: Years 52 Months 4 Days 16 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md

PARENTS

10 NAME OF FATHER: James Gill

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Ireland

12 MAIDEN NAME OF MOTHER: Cork Horgan

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Ireland

14 Informant: Mrs. Sadie Schaech

(Address): 2826 Winchester St.

15 Filed: MAY 17 1929

16 C. HAMPSON JONES, M. D. Registrar

Per ACK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 17 19 29

17 I HEREBY CERTIFY, That I attended deceased from May 1 19 29 to May 17 19 29

that I last saw h alive on May 16 19 29

and that death occurred, on the date stated above, at 6 AM m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Date of May 7 29

Was there an autopsy?

What test confirmed diagnosis? Gastroscope

(Signed) Chas F Stanton, M. D.

May 17 29 (Address) 1504 Mendenhall

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Peters Cem — Date of Burial: May 20 1929

20 UNDERTAKER: William Cook — ADDRESS: 1217 St Paul St

MAY 17 1929

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46045

CERTIFICATE OF DEATH

90 E 46045

1--PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Balto. City Hosp ST. 8-17 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Hickman

(a) RESIDENCE NO. 1420 N. Broadway ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Hickman

6 DATE OF BIRTH (month, day, and year) 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	82			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm. Hickman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Hickman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Julian Hickman

(Address) 420 N Broadway

15 Filed MAY 17 1929, HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/16/29

17 I HEREBY CERTIFY, That I attended deceased from 5/1, 1929, to 5/16, 1929, that I last saw h.im alive on 5/14, 1929 and that death occurred, on the date stated above, at 6-30 m.

The CAUSE OF DEATH* was as follows:

Senility - Generalized arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis -

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. C. Lumpkin, M. D.

5/17, 1929 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL 5/20/1929

20 UNDERTAKER H. M. Cook — ADDRESS 1217 E Pratt St

N. B.—WRITE PLAINLY, with pen and ink. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46046

124 E 46046

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Johns Hopkins Hospital St., 1-3 Ward)

2-FULL NAME John H. Slundt

(a) RESIDENCE NO. 612 S. Bradford St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Josephine Slundt

6 DATE OF BIRTH (month, day, and year) Feb 13/1902

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	27	3	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Michael B. Slundt

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Mary Ann Conrad

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto., Md.

14 Informant Josephine Slundt
(Address) 612 S. Bradford St.

15 Filed ..., 19.. [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Necrosis of Liver-Multiple Hemorrhages Stomach Bladder, etc

(Jaundice)

(duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary) Cause of Necrosis undetermined (duration) ..yrs. ..mos. ..ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? At Hopkins

What test confirmed diagnosis?

(Signed) J. H. Potter, M. D.

5/17/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus	May 18 1929
20 UNDERTAKER	ADDRESS
John M. Weber Wm	Chester

MAY 17 1929 HAMPSON JONES, M. D. Registrar

Apr 19

25

Spec.—1-10-21—M&T—1500 Bks.

Mary Baclawska

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46047

CERTIFICATE OF DEATH.

1144

E 46047

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No. ..... St., ... WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Baclaski

(a) RESIDENCE NO. 2725 Essex ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? 22 yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 15 1904

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25	2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 037

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Wajciech Krepka

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant John Baclawski

(Address) 2225 Essex St.

15 MAY 17 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 1929

17

I HEREBY CERTIFY, That I attended deceased from May 12, 1929, to May 16, 1929, that I last saw her alive on May 16, 1929, and that death occurred, on the date stated above, at 12 30 P m.

The CAUSE OF DEATH* was as follows:

Post partum Hemorrhage

(duration) yrs 5 mos One ds.

CONTRIBUTORY (Secondary) Placenta Praevia

(duration) yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? Sinai Hospital

Did an operation precede death? Yes Date of May 16-1929

Was there an autopsy? Not

What test confirmed diagnosis? Clinical

(Signed) James L. Swank M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary May 20 1929

DATE OF BURIAL

20 UNDERTAKER: John M. Weber W. A. Chester

ADDRESS

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46048 HEALTH DEPARTMENT—CITY OF BALTIMORE E 46048

CERTIFICATE OF DEATH

129

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2433 E Federal ST. 8-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John T. Jefferson

(a) RESIDENCE NO. 2433 E. Federal ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Printer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Thomas Jefferson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Sallie Jefferson

(Address) 2433 E Federal St

15 Filed MAY 17 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 9, 1929, to May 16, 1929, that I last saw h. alive on May 16, 1929 and that death occurred, on the date stated above, at 330 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Glomerulonephritis
Arterial Hypertension

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertrophy

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) Albert DeAngelis, M. D.

5/17, 1929 (Address) 2005 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel	May 20 1929
20 UNDERTAKER	ADDRESS
John C. Miller	2435 E Oliver St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Hks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46049

CERTIFICATE OF DEATH

E 46049

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 305 Otterbein ST. 21-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME alice Adams

(a) RESIDENCE NO. 305 Otterbein ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	widow

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Adams

6 DATE OF BIRTH (month, day, and year) Unknown 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	65 years			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Eliza Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant James Francis

(Address) 1432 Hartman ave

15 Filed MAY 17 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15-1929

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1928, to May 15, 1929, that I last saw h er alive on May 14, 1929 and that death occurred, on the date stated above, at 8.30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis + Myocarditis.

CONTRIBUTORY (Secondary) (duration) 6 yrs. mos. ds. Pulmonary Oedema (duration) — yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? none

(Signed) D W Francisco, M. D.

5/17 1929 (Address) 122 W Lee

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cem DATE OF BURIAL May 18 19 29

20 UNDERTAKER John H Joachim ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks. Joaccium Mendes Carvalho

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46050

CERTIFICATE OF DEATH

E 46050

38

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. President Hosp. St. 17-24 Ward)

2-FULL NAME Jaquim C. Carvalho

(a) RESIDENCE NO. 203 Argyle St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col.

5 Single, Married, Widowed or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margie Carvalho

6 DATE OF BIRTH (month, day, and year): Feb 29th 1889

7 AGE: Years 40 | Months 2 | Days 18 | IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Cook
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city): Santiago
(State or country) Cape Verde Island

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant: Margie Carvalho
(Address) 1206 Argyle Ave.

Filed ... 19... C. HAMPSON JONES, Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): May 15th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy & Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Thrombosis.

Coronary Artery. (duration) yrs. Sudden mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) F. C. Flinn, M. D.

May 15 1929 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: May 19 29

20 UNDERTAKER: John H. Toadvine — ADDRESS

MAY 17 1929

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46051

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46051

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 19 S. Janney ST. 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Nick Konig

(a) RESIDENCE NO. 19 S. Janney ST., 26 WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. dis. 6 How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 11th 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
			6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Dan Konig

11 BIRTHPLACE OF FATHER (city or town) Russia
(State or country)

12 MAIDEN NAME OF MOTHER Mollie Joynesky

13 BIRTHPLACE OF MOTHER (city or town) Austria
(State or country)

14 Informant Dan Konig (Father)
(Address) 19 S. Janney st.

15 Filed MAY 18 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17th 1929

17 I HEREBY CERTIFY, That I attended deceased from May 11, 1929 to May 17, 1929

that I last saw h. alive on May 17, 1929

and that death occurred, on the date stated above, at 7:45 P. m.

The CAUSE OF DEATH* was as follows:

Atelectasis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William H. Davis M. D.

(Address) 801 N. Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Lebanon Cemetery	May 19 1929
20 UNDERTAKER Kelly-Gilmore Co.	ADDRESS 705 E. Monument

IMPORTANT. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS will please write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46052

CERTIFICATE OF DEATH

E 46052

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 336 S. Newkirk ST., 26 37 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Conrad H. Nos.

(a) RESIDENCE NO. 336 S. Newkirk ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Nos.

6 DATE OF BIRTH (month, day, and year) Dec. 4-1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Mary Nos.

(Address) 336 S Newkirk St.

15 MAY 18 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May. 17-1929

17 I HEREBY CERTIFY, That I attended deceased from May 6 . 1929 . to May 17 . 1929.

that I last saw him alive on May 16 . 1929

and that death occurred, on the date stated above, at 8 45 A. m.

The CAUSE OF DEATH* was as follows:

P Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Auscultation

(Signed) Frank A. Glantz, M. D.

May 17 1929 (Address) 3244 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oaklawn Cemetery	May 20 1929
20 UNDERTAKER George W. Zibler	ADDRESS 1737 E Eager St

mation should be carefully supplied. AGE should be stated in YEARS, MONTHS and DAYS. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46053

CERTIFICATE OF DEATH

105

E 46053

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2000 Orleans ST. 6-9 WARD)

2—FULL NAME Ernest J. Goggins

(a) RESIDENCE NO. 2000 Orleans ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

.a If married, widowed, or divorced HUSBAND of (or) WIFE of Grace Hosthra Goggins

6 DATE OF BIRTH (month, day, and year) Sept 16 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56.	8		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoe Finisher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Milton Mills (State or country) N.H.

PARENTS

10 NAME OF FATHER Frank Goggins

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Hampshire

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont Know

14 Informant Mrs. Grace Goggins

(Address) 2000 Orleans St

MAY 18 1929 Filed ..... 19 ..... C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 1929

17 I HEREBY CERTIFY, That I attended deceased from 5-13 19 29 to 5-16 19 29

that I last saw h alive on 5-16 19 29

and that death occurred, on the date stated above, at 4:47 a m.

The CAUSE OF DEATH* was as follows:

Bronchial Asthma & Emphysema

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J Geoghegan M. D.

5/16 19 29 (Address) 4 E Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem

DATE OF BURIAL May 18 1929

20 UNDERTAKER John Merrick

ADDRESS 2008 Orleans

Information should be carefully supplied. AGE should be stated EXACTLY. If DECEASED was under one year, state AGE IN DAYS; if under one day, state HOURS or MINUTES. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46054

CERTIFICATE OF DEATH

100-001 E 46054

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 702 Kenable Ave 17-5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry W. Sauerwald

(a) RESIDENCE NO. 702 Kenable Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

Information should be carefully supplied. All items should be filled in. Use ditto marks (") only when they will not be misunderstood. Write plainly in ink. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emma Sauerwald

6 DATE OF BIRTH (month, day, and year): June 17-1866

7 AGE: Years 62 | Months 11 | Days | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Musician

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md

PARENTS

10 NAME OF FATHER: Jacob Sauerwald

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Sara Rupp

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Elizabeth Lemmon

(Address) 315 N Robinson St

15 Filed MAY 18 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 17 1929

17 I HEREBY CERTIFY, That I attended deceased from May 1 1929 to May 16 1929

that I last saw him alive on May 16 1929

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? None

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) O. L. Long, M. D.

5/18/1929 (Address) 2711 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem

DATE OF BURIAL: May 20 1929

20 UNDERTAKER: John Ellis

ADDRESS: E Biddle

Spec.—2-29-28—L. F. S.—500 Blks.

E 46055

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 46055

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1805 Edmondson Ave ST., 16-27 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Josephine S. Anderson

(a) RESIDENCE NO. 1805 Edmondson Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eugene S. Anderson

6 DATE OF BIRTH (month, day, and year) June 30, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	56	10	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Lewis T. Wilborn

11 BIRTHPLACE OF FATHER (city or town) Portsmouth
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Alice Wall

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mr. Eugene W. Anderson

(Address) 1805 Edmondson Ave.

15 Filed MAY 18 1929, C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 1 —, 1929, to May 16th, 1929 that I last saw her alive on May 16th, 1929 and that death occurred, on the date stated above, at 2.15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(duration) 2 yrs. 5 mos. 15 ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Howard E. Woodcock, M. D.

5/17, 1929 (Address) 530 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL May 18 19 29

20 UNDERTAKER Fox & Cook

ADDRESS 1001 West Baltimore St.

mation should be carefully supplied. Ages should be stated in every case. Every question must be answered. Write plainly. Use ink. Do not abbreviate. Cause of death must be stated by a physician. Occupation should be stated in every case. Every question must be answered. Write plainly. Use ink. Do not abbreviate. Cause of death must be stated by a physician. Occupation should be stated in every case. Every question must be answered. Write plainly. Use ink. Do not abbreviate. Cause of death must be stated by a physician. Occupation should be stated in every case. Every question must be answered. Write plainly. Use ink. Do not abbreviate. Cause of death must be stated by a physician. Occupation should be carefully supplied. Ages

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46056

CERTIFICATE OF DEATH

129 E 46056

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 1809 Wilkens Ave., ST., 18-28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emma Ozella Stier

(a) RESIDENCE NO. 1809 Wilkens Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James J. Stier

6 DATE OF BIRTH (month, day, and year) July 1, 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	10	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 0 3 1

(c) Name of employer At Home

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Richard C. Robinson

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Emily Jane Harford

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mrs. Lillian V. Stewart
(Address) 1809 Wilkens Avenue

15 Filed MAY 18 1929, 19 C. HAMPSON JONES, M. D.
By Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15, 1929

17 I HEREBY CERTIFY, That I attended deceased from 3-20-, 1929, to May 15, 1929, that I last saw her alive on May 15, 1929 and that death occurred, on the date stated above, at 4.15 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) — yrs. — mos. 2 ds.

CONTRIBUTORY (Secondary) Valvular heart disease — Nephritis (duration) over 2 mos. yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical history

(Signed) Henry G. Ohlo M. D.

5/16, 19 29 (Address) 1203 W. Fayette Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL May 18 19 29

20 UNDERTAKER Joseph L. Cook

ADDRESS 1002 West Baltimore St.

mation should be carefully supplied. Any should be omitted. Exact statement of OCCUPATION OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46057

CERTIFICATE OF DEATH

129 ✓ E 46057

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3016 W. North Ave. ST. 15-67 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Francis Ruth Shyers

(a) RESIDENCE NO. 3016 W. North Avenue ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Stephen L. Shyers

6 DATE OF BIRTH (month, day, and year) June 17, 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John Henry V. Ackerman

11 BIRTHPLACE OF FATHER (city or town) New Brunswick
(State or country) New Jersey

12 MAIDEN NAME OF MOTHER Josephine Felter

13 BIRTHPLACE OF MOTHER (city or town) New Brunswick
(State or country) New Jersey

14 Informant Mrs. C. T. Grouse

(Address) Hanover, Md.

15 Filed MAY 19 1929, 19 C. HAMPSON JONES M.
Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17, 1929

17 I HEREBY CERTIFY, That I attended deceased from 5-14-, 1929, to 5-17-, 1929,

that I last saw her alive on 5-16-, 1929

and that death occurred, on the date stated above, at 2.01 A. m.

The CAUSE OF DEATH* was as follows:

Nephritis - Interstitial
Mitral Insufficiency

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Clinical findings

(Signed) Wm H. Howard, M. D.

5/17, 1929 (Address) 2523 Liberty Heights Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	May 20 19 29
20 UNDERTAKER	ADDRESS
Wm. H. Cook	1005 West Baltimore St.

mation should be carefully supplied. ... OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46058

CERTIFICATE OF DEATH

74-001 E 46058

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Franklin Sq Hosp St. 46 26 Ward)

2-FULL NAME Della Wilson

(a) RESIDENCE NO. 1104 Edmonson Ave Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas. Wilson

6 DATE OF BIRTH (month, day, and year) July 9 1889

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	39	10	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work W. W.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto City

PARENTS

10 NAME OF FATHER Wm Jobbs

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Esther Thomas

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Delaware

14 Informant Ernest. Thomas
(Address) 821 East Lanvale St

15 Filed MAY 18 1929 16 HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

a So Phthisis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas W Brode M. D.

5/16. 1929 (Address) 3604 Va Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery — DATE OF BURIAL 5/19/29 1929

20 UNDERTAKER Mrs. Katie R. Williams — ADDRESS 322 Schroeder St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46059 HEALTH DEPARTMENT—CITY OF BALTIMORE E 46059

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO. 74002

CITY OF BALTIMORE: (No. 16-39 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anthony Patti

(a) RESIDENCE NO. 3702 E. Pratt ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie Patti

6 DATE OF BIRTH (month, day, and year) 7/4/1883 ~~Unknown~~

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	9	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Salvadore Patti

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Grace Fainularo

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Records of

(Address) Baltimore City Hospitals

15 Filed MAY 18 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16, 1929

17 I HEREBY CERTIFY, That I attended deceased from August 25, 1928, to May 16, 1929, that I last saw him alive on May 16, 1929 and that death occurred, on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Hemiplaresis, thrombotic

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Thrombosis cerebral vessel

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home & here

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical exam.

(Signed) Warren H. Wilson, M. D.

, 19 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	5/20 1929
UNDERTAKER George J. Ruth 1735	ADDRESS Harford Ave

mation should be carefully supplied. AGE should be stated EXACTLY. INFORMATION OF OCCUPATION is important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46060

183 E 46060

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 3007 Presbury St., 7-12 Ward)

2-FULL NAME Genevieve Hardesty

(a) RESIDENCE NO. 2708 Mathews St.. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: No

6 DATE OF BIRTH (month, day, and year): June 11-1912

7 AGE: Years 16 | Months 11 | Days 5 | IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Maid
(b) General nature of industry, business, or establishment in which employed (or employer): 070
(c) Name of employer:

9 BIRTHPLACE (city or town): Baltimore
(State or country):

PARENTS

10 NAME OF FATHER: John Harding

11 BIRTHPLACE OF FATHER (city or town): Balto.
(State or country):

12 MAIDEN NAME OF MOTHER: Ella M. Hitchcock

13 BIRTHPLACE OF MOTHER (city or town): Baltimore
(State or country):

14 Informant: John Harding
(Address): 2708 Mathews

15 Filed ..... 19 ..... HAMPSON JONES, Registrar

MAY 18 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 16th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy & Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage due to pistol wound of Neck (Accident) (duration) yrs. Sudden

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 3007 Presbury St.

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) H. F. Kirk, M. D.
(Address) May 17 1929 Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn. DATE OF BURIAL: May 19 29.

20 UNDERTAKER: Edmonds & Son ADDRESS: 2115 Eutaw Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46061

CERTIFICATE OF DEATH

129 E 46061

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1817 South Ave ST.) 27-64 (WARD)

2—FULL NAME Annie Virginia Farnsworth

(a) RESIDENCE NO. 1817 South Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
(or) WIFE of Joseph Farnsworth

6 DATE OF BIRTH (month, day, and year) Aug. -1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Garrett D Johnson

11 BIRTHPLACE OF FATHER (city or town) Harford Co.
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah Carr

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Maryland

14 Informant Mrs J E Costello (daughter)
(Address) 1817 South Ave.

15 MAY 18 1929, 19 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1929, to May 15, 1929, that I last saw her alive on May 15, 1929 and that death occurred, on the date stated above, at 3.15 P.m.

The CAUSE OF DEATH* was as follows:

Senile degeneration - Chronic Bright's disease

Contributory Regurgitation with (H) autopsy

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) C H Watson, M. D.

5.17.1929 (Address) 1818 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cemetery	May 19 1929
20 UNDERTAKER Stewart & Co.	ADDRESS Balto Md.

MAY 18 1929

MATTER SHOULD BE TYPEWRITTEN OR PRINTED. Avoid abbreviations. Write plainly with pen and ink. Do not use lead pencil. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46062 — 101-001 — E 46062

CERTIFICATE OF DEATH

1—PLACE OF DEATH: Baltimore City Hospitals — REGISTERED NO.

CITY OF BALTIMORE: (No.) ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME: Walter Gaines

(a) RESIDENCE NO. 726 Kirsch ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Liza Gaines

6 DATE OF BIRTH (month, day, and year): ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34 (34)			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Junk dealer

(b) General nature of industry, business, or establishment in which employed (or employer): 045

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Texas

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Records of

(Address) Baltimore City Hospitals

15 Filed MAY 18 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 17, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 14, 1929, to May 17, 1929, that I last saw h... alive on May 17, 1929 and that death occurred, on the date stated above, at 1 (A.M.)

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No X Ray

What test confirmed diagnosis?

(Signed) [illegible], M. D.

. 19 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cem	5-20th 1929
20 UNDERTAKER	ADDRESS
Jas. M. Skinner	1625 E. Monument st

mation should be carefully supplied. AGE should be stated EXACTLY. THE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

MAY 18 1929

Cor.—10-10-29—A Co.—100 Bks.

E 46063

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

113 E 46063

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 311 N. Strieker St., 14-27 Ward)

2-FULL NAME Delores C. Wade

(a) RESIDENCE NO. 311 N. Strieker St., ... Ward .....

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 9 mos. ds. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) aug-1928

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
		9		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Roy. A. Wade

11 BIRTHPLACE OF FATHER (city or town) N. C.
(State or country)

12 MAIDEN NAME OF MOTHER Mary Flowers

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Roy. A. Wade
(Address) 311 N. Strieker

15 Filed ..... C. HAMPSON JONES, M. D., Registrar
Per .....

MAY 18 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1925

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH was as follows:

Bronchopneumonia
Diarrhoea

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Chas. H. Brooke M. D.

5/18. 1925 (Address) 3601 3rd Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL May 18 1929

20 UNDERTAKER Mrs Katie R Williams — ADDRESS 322 N. Schroeder

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46064

CERTIFICATE OF DEATH

143-003

E 46064

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Johns Hopkins Hospital St. 5-4 Ward)

2-FULL NAME Harriett Kane

(a) RESIDENCE NO. 1433 Orleans St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 6/1911

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	17	11	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Thomas Kane

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Hattie Hilliard

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto., Md.

14 Informant Hattie Kane Travers
(Address) 1433 Orleans St

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema (Acute)
Chr. Aortic-Endocarditis
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Still Birth 5 hrs. before death (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? At Hopkins Hospital

What test confirmed diagnosis?

(Signed) J. H. Corner, M. D.

5/17/29 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	May 20 1929

20 UNDERTAKER Chas. W. Lunsford ADDRESS 116 N. Caylus St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAY 18 1929

Spec.—2-29-28—L. F. S.—500 Bks.

E 46065 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-00 E 46065

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1620 W. Lexington ST. 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Eva Tompkins

(a) RESIDENCE NO. same ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work domestic

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Worcester Co Pa

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) " (State or country)

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) " (State or country)

14 Informant Maryland Baptist Home

(Address) 1620 W Lexington st

15 C. HAMPSON JONES, M. D.

Registrar

MAY 18 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/16/29

17 I HEREBY CERTIFY, That I attended deceased from 5-14-29, 19 to 5-16-29 19, that I last saw h alive on " 19 and that death occurred, on the date stated above, at 10.30 P m.

The CAUSE OF DEATH* was as follows:

apoplexy

CONTRIBUTORY (Secondary) Bronchial asthma (duration) yrs. mos. 3 ds.

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. M. Condon, M. D.

5-17-1929 (Address) 1524 Hollins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Auburn — DATE OF BURIAL: May 20 1929

20 UNDERTAKER: Joseph A Lively — ADDRESS: 1022 Mount st

mation should be carefully supplied. AGE should be stated EXACTLY. If unknown, approximate. OCCUPATION must be stated EXACTLY. If unknown, approximate. OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 46066

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 46066

REGISTERED NO.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 9-46 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anne Stevens

(a) RESIDENCE NO. 2914 Montebello Ter. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 16 1879

7 AGE

Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
50	4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cashier

(b) General nature of industry, business, or establishment in which employed (or employer) 09

(c) Name of employer Travellers Ins Co Butte

9 BIRTHPLACE (city or town) Butte

(State or country) Md

PARENTS

10 NAME OF FATHER Nicholas Sterns

11 BIRTHPLACE OF FATHER (City or town) Balto

(State or country) md

12 MAIDEN NAME OF MOTHER Anne R Cullum

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) md

14 Informant Mrs Anne R. Sterns

(Address) 2914 Montebello Terrace

15 Filed C. HAMPSON JONES, M. D. Registrar

BY 181929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/17/29

17 I HEREBY CERTIFY, That I attended deceased from 5/17/29, 19..., to 5/17/29, 19..., that I last saw her alive on 5/17/29, 19..., and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis & Hypertension

(duration) several yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) Sudden yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) E. K. Winstead, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery — Date of Burial May 20 1929

20 UNDERTAKER John B. Spence — ADDRESS 1325 N Caroline St

Cor.—10-10-29—A Co.—100 Bks.

E 46067

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46067

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 923 Mosris St. 11-24 Ward)

2-FULL NAME Melvina Brown

(a) RESIDENCE NO. 923 Mosris. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAY 18 1929

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col

5 Single, Married, Widowed or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Brown.

6 DATE OF BIRTH (month, day and year): 1880

7 AGE: Years 48 | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laundress
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town): N. C.
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant: John Brown
(Address) 923 Mosris

15 Filed ..... C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): May 16th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to Died death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Endocarditis

(Duration) yrs. One mos. ds.

CONTRIBUTORY (Secondary) Rheumatism

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Collins Corner, M. D.

May 16 1929 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cem.

DATE OF BURIAL: May 19 1929

20 UNDERTAKER: Adolphus Hubstenberger

ADDRESS: 1902 N. Eutaw St.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46068 ✓ 90 E 46068

CERTIFICATE OF DEATH

1—PLACE OF DEATH — REGISTERED NO. 27-48

CITY OF BALTIMORE: (No. 108 St. Dunstans Road ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles H. Schnepfe

(a) RESIDENCE NO. 108 St. Dunstans Road ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertie Beryl Auld

6 DATE OF BIRTH (month, day, and year) Aug 14, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	9	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Public Accountant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Charles H. Schnepfe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Emma Mosburger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Mr. Howard A. Schnepfe

(Address) 2800 Beach Ave.

15 Filed MAY 18 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1924, to May 16, 1929, that I last saw h. alive on May 16, 1929 and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Acute dilatation of heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary edema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of None

Was there an autopsy? None

What test confirmed diagnosis?

(Signed) Geo A Stewart, M. D.

May 16 1929 (Address) 904 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemy	May 18, 1929

20 UNDERTAKER ADDRESS

John C. Rieman & Son 1900 Eutaw Place

IMPORTANT.—WRITE PLAINLY with pen and ink. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 46069 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46069

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 21 N. Gilmore ST. 14-27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert P. Williams

(a) RESIDENCE NO. 21 N Gilmore ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Zola Williams

6 DATE OF BIRTH (month, day, and year) Oct 27 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	6	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Asst Standard Oil Co

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Robert Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Zola Williams

(Address) 21 N Gilmore

15 C. HAMPSON JONES, M. Registrar

Per

MAY 18 1929

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ... mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/16/29 19

17

I HEREBY CERTIFY, That I attended deceased from 7/19/19 29, to 5/16/29, that I last saw h— alive on 5/16/29, and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Hypertension

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Apoplexy

(duration) 2/14/29 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Appt

(Signed) Bernard J. Terry, M. D.

5/17/29 (Address) 910 W. Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL May 20 19 2

20 UNDERTAKER John J. Fields — ADDRESS 1200 W Lombard

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46070

CERTIFICATE OF DEATH

129 E 46070

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2563 Hollins ST. 70-69 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emma Lee McCurley

(a) RESIDENCE NO. 2563 Hollins ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edward E McCurley

6 DATE OF BIRTH (month, day, and year) Oct 10 1874

7 AGE	Years	Months	Days	If LESS than 1 day,.... hrs. or.... min.
	54	7	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 031

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER John Benney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Estella Shepard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Edw E McCurley

(Address) 2563 Hollins St

15 Filed G. HAMPSON JONES, M. D. Registrar

AY 187929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16/29

17 I HEREBY CERTIFY, That I attended deceased from Feb, 1929, to May, 1929, that I last saw h[illegible] alive on May 16, 1929 and that death occurred, on the date stated above, at 8[illegible] P m.

The CAUSE OF DEATH* was as follows:

(Disease)

Cardio-vascular Renal disease

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Frederic Y.D. Wack, M. D.

, 19 (Address) 827 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL May 20 1929

20 UNDERTAKER John Fields — ADDRESS 1201 W Lombard

Information should be carefully supplied, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46071

CERTIFICATE OF DEATH

129 E 46071

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 133 N. Rose ST. 6-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Marquardt

(a) RESIDENCE NO. 133 N. Rose ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if foreign birth 67 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William H Marquardt

6 DATE OF BIRTH (month, day, and year) Aug. 18, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	73	9	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER John George Kaiser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Kaiser

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant John George Marquardt (Address) 133 N. Rose St.

15 [illegible] C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-16-29

17 I HEREBY CERTIFY, That I attended deceased from 4-1-29 to 5-15-29, 19..

that I last saw her alive on 5-15-29

and that death occurred, on the date stated above, at 9:20 P. M.

The CAUSE OF DEATH* was as follows: Nephritis, Hypertension

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) [illegible] M. D.

(Address) 100 N. Wolfe St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cem	5/19 1929
20 UNDERTAKER L. Heimann	ADDRESS 37 S. Bway

MAY 18 1929

INFORMATION SHOULD BE GIVEN by someone who knows the facts. Exact statement of OCCUPATION OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 46072

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46072

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Curtis Bay Cola Pier. St. 25-77 Ward)

2-FULL NAME Joseph Gray.

(a) RESIDENCE NO. 579 Columbia Rd. Boston Mass. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	81	----------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Mess Boy
(b) General nature of industry, business, or establishment in which employed (or employer) S/S Yaka.
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Boston, Mass.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Henry Gray. (brother)
(Address) 579 Columbia Rd. Boston Mass.

15 Filed ..... 19.. C. HAMPSON JONES, M. D.
Registrar
By .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 14, 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning.
Accidental fall from a pier.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted If not at place of death? -------

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) [illegible], M. D.

5/18. 1929 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Boston Mass	5/19 1929
20 UNDERTAKER	ADDRESS
[illegible]	318 E. [illegible] St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAY 18 1929

Cor.—10-10-29—A Co.—100 Bks.

E 46073

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1431001 E 46073

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Provident Hosp. 17-24 Ward

2-FULL NAME Elena Thomas Spruill

(a) RESIDENCE NO. 595 Oxford St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 Color or Race: Col

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of: Nelson

6 DATE OF BIRTH (month, day, and year): 1898

7 AGE: Years 30 | Months | Days | IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laundress
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer: 041

9 BIRTHPLACE (city or town): Va
(State or country): " "

PARENTS

10 NAME OF FATHER: [illegible]

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant: Provident Hosp. Record Division St.
(Address)

15 Filed May 18 1929 C. HAMPSON JONES, M. D., Registrar
By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): May 14 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to h death on the day stated above.
The CAUSE OF DEATH* was as follows:

Mitr Carriage
Unavoidable
CONTRIBUTORY (Secondary) yrs. 5 mos. ds.
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No Date of
Was there an autopsy? No Provident Hosp
What test confirmed diagnosis?
(Signed) Ely Shuh M. D.
May 15 1929 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Norfolk | DATE OF BURIAL: 5 18 29

20 UNDERTAKER: Rachmel & Hrusloff Bidd | ADDRESS 1718

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of the above information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46074

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

161-001

E 46074

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. St. Joseph's Hosp. ST. 26-37 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby De Boer

(a) RESIDENCE NO. 3435 Toland ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 5/15/29

7 AGE Years	Months	Days	If LESS than 1 day hrs. or min.
		2	3

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) St. Joseph's Hosp
(State or country)

PARENTS

10 NAME OF FATHER Carl Van Billiard

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Bethlehem Pa.

12 MAIDEN NAME OF MOTHER Raymond De Boer

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country)

14 Informant

(Address)

15 Filed 19

Registrar

AY 18 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/15/29

17 I HEREBY CERTIFY, That I attended deceased from 5/14, 19 29, to 5/15, 19 29, that I last saw h alive on 5/15, 19 29, and that death occurred, on the date stated above, at 8 a m.

The CAUSE OF DEATH* was as follows:

P

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
Premature Birth (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. Hampson Jones, M. D.

19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	19
20 UNDERTAKER	ADDRESS

MAY 16 1929

mation should be carefully supplied. Any blanks will delay burial. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

L 88-103

E 46075

CERTIFICATE OF DEATH.

E 46075
REGISTERED NO.

1-PLACE OF DEATH Union Memorial Hospital

City of BALTIMORE: (No. Calvert's 33rd St., 27-48 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Marie Ann Dunbar

(a) RESIDENCE NO. 307 Tunbridge Road St. Homeland Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): January 24 1925

7 AGE: Years 4 Months 3 Days 23 IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country) Washington D. C.

PARENTS

10 NAME OF FATHER John T. Dunbar

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Washington D. C.

12 MAIDEN NAME OF MOTHER Emma M. Clemens

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) St Louis Mo

14 Informant: Mr John T. Dunbar

(Address) 307 Tunbridge Road

Filed MAY 19 1929, 19 H. MASON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-17 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inq (Inquest, autopsy or inquiry.) find that said deceased came ~~were~~ to ~~her~~ death on the day stated above.

The CAUSE OF DEATH was as follows:

Fractured skull

Auto Accident

accidental

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) None

(duration) ....yrs. ....mos. ....ds.

(Signed) H. Morrissey M. D.
(Coroner)

5/18, 1929 (Address) 3532 Roland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Cem Govanstown — Date of Burial: May 20 1929

20 UNDERTAKER: Henry H. Jenkins Sons Co — ADDRESS: Cathedral & Mulberry Sts

F. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAY 19 1929

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46076

CERTIFICATE OF DEATH.

E 46076
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: (No. Caton & Wilkens Ave ST. WARD)

2-FULL NAME Mrs Mary Meyers

(a) RESIDENCE NO. Emmitsburg Md ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 12 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: ~~Male~~ FEMALE

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of or) WIFE of: William J. Meyers

6 DATE OF BIRTH (month, day, and year): Dec

7 AGE: Years 30; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: at home
(b) General nature of industry, business, or establishment in which employed (or employer): 037
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS
10 NAME OF FATHER: Robert Kreitz
11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.
12 MAIDEN NAME OF MOTHER: Mary Cook
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant: William Meyers
(Address): Emmitsburg Md

15 Filed MAY 19 1929 H. [illegible] JONES, M. D. Registrar
BY [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5-18 1929

17 I HEREBY CERTIFY, That I attended deceased from 4-6, 1929, to 5-18, 1929, that I last saw her alive on 5-18, 1929, and that death occurred, on the date stated above, at 12 40 P m.

The CAUSE OF DEATH* was as follows:
Toxic thyroid (Colloid-adenomatous type)
(duration) yrs. 5 mos ds.
CONTRIBUTORY (Secondary) Myocarditis - Probable embolism to brain. Toxemia.
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of 5-18-29.
Was there an autopsy? No operation finding
What test confirmed diagnosis? Basal metabolism.
(Signed) J. M. Cruson, M. D.
, 19 (Address) St Agnes Hospital Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Emmitsburg Md — DATE OF BURIAL: May 20 1929

20 UNDERTAKER: M. F. Shuff, Jr — ADDRESS: Emmitsburg Md

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-27—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46077

CERTIFICATE OF DEATH.

97-001 E 46077

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (NO. Monument & Busay ST. 713 WARD)

2-FULL NAME Mr. Sol Nachman

(a) RESIDENCE NO. Newport News, Va ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ida Solomon

6 DATE OF BIRTH (month, day, and year): May 19 74

7 AGE — Years: 55 — Months: 0 — Days: 0 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Merchant

(b) General nature of industry, business, or establishment in which employed (or employer): Dept Store

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Joshua Nachman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Ida Solomon (Address) Newport News Va.

15 Filed MAY 19 1929 — H. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 19 1929

17 I HEREBY CERTIFY, That I attended deceased from May 14, 1929, to May 19, 1929, that I last saw him alive on May 19, 1929, and that death occurred, on the date stated above, at 12 N.

The CAUSE OF DEATH* was as follows:

Septicemia

CONTRIBUTORY (Secondary) Cellulitis of Nose (duration) yrs. mos. 4 ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Physical Signs

(Signed) Frederick S. Wolf M. D.

5-18 1929 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Newport News Va — DATE OF BURIAL: May 19 1929

20 UNDERTAKER: Jack Lewis — ADDRESS: 1439 E. Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS IS A LEGAL DOCUMENT. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46078

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 ✓ E 46078

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1913 Druid Hill Ave ST 14-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Deverby A. Henry

(a) RESIDENCE NO. 1913 Druid Hill Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Henry

6 DATE OF BIRTH (month, day, and year): [illegible] 1859

7 AGE: Years 70 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Teamster

(b) General nature of industry, business, or establishment in which employed (or employer): 023

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: John W. Henry

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Nash

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mary Henry

(Address) 1913 Druid Hill

MAY 19 1929

Filed [illegible] HAMILTON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 16 1929

17 I HEREBY CERTIFY, That I attended deceased from April 9, 1929 to May 16 1929

that I last saw h[illegible] alive on May 16, 1929

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinically

(Signed) J S McCard, M. D.

5/18, 1929 (Address) 1005 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL: May 19 1929

20 UNDERTAKER: John H. Toadvine — ADDRESS 1027 Druid Hill

IMPORTANT: Before signing, read carefully and see that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 46079

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 126 E 46079

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 1-4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Baublitz

(a) RESIDENCE NO. Chestnut Ridge ST. ..... WARD Reisterstown Md

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	married

5a If married, widowed, or divorced (01) HUSBAND of (01) WIFE of Howard

6 DATE OF BIRTH (month, day, and year) 2/22/87

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	2	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... H W

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Alfred Bosley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Louisa Combs

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed MAY 19 1929 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1929

17 I HEREBY CERTIFY, That I attended deceased from May 12, 1929, to May 18, 1929, that I last saw her alive on May 18, 1929, and that death occurred, on the date stated above, at 2.25 P. m.

The CAUSE OF DEATH* was as follows:

Generalized Peritonitis

Septicemia (β hemol. strept)

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Endocarditis acute- Mitral + aortic incompetency

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of About May 6 by outside doctor

Was there an autopsy? Yes

What test confirmed diagnosis? Blood Culture

(Signed) George S. Brumbaugh, M. D.

May 19 1929 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Chestnut Ridge Balto Co. Md

DATE OF BURIAL May 21 1929

20 UNDERTAKER Wm. C. Burdon & Son

ADDRESS Sparks

S. B.—WRITE PLAINLY, WITH UNFADING INK. The information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46080

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

24-001

E 46080

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1100 William St. (ST.) (WARD) 24-33

2—FULL NAME Helena Smith

(a) RESIDENCE NO. (Usual place of abode) 1100 William St. ST., WARD (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles L. Smith

6 DATE OF BIRTH (month, day, and year) Sept. 18 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	8	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Cook

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mr. John Smith

(Address) 1100 William St

15 Filed ..... 19 ..... JAMES M. JONES, M. D. Registrar

MAY 19 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18/29

17 I HEREBY CERTIFY, That I attended deceased from Feb - 4. 1929, to May 18. 1929,

that I last saw her alive on May 18. 1929

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 3 mos. 13 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? no Date of -

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) W. W. Buxton, M. D.

5/18, 1929 (Address) 301 Eleventh St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cemetery	May 21 1929
20 UNDERTAKER	ADDRESS
I. Frew McCully	130 E. Fort

IMPORTANT—Read carefully, and see that DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46081

CERTIFICATE OF DEATH

94-001

E 46081

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3005 Brighton ST. 16-67 WARD)

2—FULL NAME Sarah Francis Mcnnally

(a) RESIDENCE NO. 3005 Brighton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Albert Mcnnally

6 DATE OF BIRTH (month, day, and year) Nov. 17 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
86. 87		6	5	

8 OCCUPATION OF DEACEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Richmond Va

PARENTS

10 NAME OF FATHER Hamilton Mcanley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Warfield

(Address) 3005 Brighton

15 Filed MAY 19 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1929, to May 17, 1929, that I last saw her alive on May 14, 1929 and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis with hypertension (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Phy. examination

(Signed) J. Sheldon Eastland M. D.

19 (Address) 373 Med. Arts Bldg.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem

DATE OF BURIAL 5/20 1929

20 UNDERTAKER I. Frew McCully

ADDRESS 130 E Fort

IMPORTANT—In filling out this Certificate, the answers to questions must be full and complete, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46082

CERTIFICATE OF DEATH

57 E 46082

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Sinai Hospital ST. 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Cloreal Feldman

(a) RESIDENCE NO. 135 N. Exeter ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Yetta Feldman

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Morris Feldman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Bessie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Yetta Feldman (Address) 135 N. Exeter St

15 Filed MAY 19 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/18/29

17 I HEREBY CERTIFY, That I attended deceased from May 14, 1929, to May 18, 1929, that I last saw h/m alive on May 18, 1929 and that death occurred, on the date stated above, at 3 9 m.

The CAUSE OF DEATH* was as follows:

1(a) Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Dr. Clifford Day.

(Signed) [signature], M. D.

19 (Address) Sinai Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Workmen Circle	5/19 1929

20 UNDERTAKER Jack Levin ADDRESS 1439 E Balt St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46083

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

40 E 46083

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew Home for Aged & Infirm WARD) 10

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary R. Perman

(a) RESIDENCE NO. 2100 E. Balto ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if foreign birth? 19 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Nathan Perman

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Solomon Wilkus

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1439 E. Balto St

15 C. HAMPSON JONES, M. D.

Registrar

AY 191929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18/29

17 I HEREBY CERTIFY, That I attended deceased from May 9. 19 29. to May 18. 19 29.

that I last saw h alive on May 17 . 19 29

and that death occurred, on the date stated above, at 10 9 m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis.

(duration) 15 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

. 19 (Address) 1813 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Home Cem Run	5/19 19 29

20 UNDERTAKER Jack Lewis ADDRESS 1439 E Balto St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46084

CERTIFICATE OF DEATH.

E 46084

74-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1440 N Mount St. 15-21 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Jane Brooks

(a) RESIDENCE NO. 1440 N. Mount ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Henry Brooks

6 DATE OF BIRTH (month, day, and year) March 1, 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67	2	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Midwife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Public

9 BIRTHPLACE (city or town) (State or country) Marion W. Va

PARENTS

10 NAME OF FATHER William Coleman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Monon W. Va

12 MAIDEN NAME OF MOTHER Ellen Chatman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Monon W. Va

14 Informant Grace Brooks

(Address) 1440 N. Mount

15 Filed MAY 19 1929

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1929

17 I HEREBY CERTIFY, That I attended deceased from October 4 1928 to May 17 1929, that I last saw h alive on May 15 1929 and that death occurred, on the date stated above, at 12.15 A. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia (Rt side Brain).

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage Artery Sclerosis

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death? 1440 N Mount.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical History

(Signed) Wm. H. Wright, M. D.

May 18. 1929 (Address) 1209 Presbrey Ave 81

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem DATE OF BURIAL 5/19 1929

20 UNDERTAKER Samuel Wensley ADDRESS 5 N Bridge

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46085

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1929 E 46085

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 706 N. Fulton Ave. ST. 16-22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary F. Hynson,

(a) RESIDENCE NO. 706 N. Fulton Ave. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (write the word)
Female	White	Widow

6a If ~~married~~, widowed, ~~or divorced~~ (or) ~~HUSBAND~~ WIFE of Christopher C. Hynson,

6 DATE OF BIRTH (month, day, and year) April 1, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	1	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Accamac Co.
(State or country) Virginia

PARENTS

10 NAME OF FATHER Bagwell Mason,

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

14 Informant Mrs Barrow

(Address) 706 N. Fulton Ave.

15 Filed MAY 19 1929 19 HAMSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY, That I attended deceased from Dec 27, 1928, to May 18, 1929, that I last saw h- alive on May 18, 1929 and that death occurred, on the date stated above, at 6 30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous nephritis,

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)* Pulmonary Stasis and Cardiac failure (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) J. Bernard Jones M. D.

5/9, 1929 (Address) 1707 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION~~ OR REMOVAL Chestertown Md — DATE OF BURIAL 19

20 UNDERTAKER Geo W Little — ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 46086

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

118-001

E 46086

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No. Woodmont & Broadway ST. 8-16 WARD)

2-FULL NAME Mrs. Emma Herman

(a) RESIDENCE No. 1906 N. Patterson Park Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 20. 1867

7 AGE Years 61 Months 2 Days 27 If LESS than 1 day, ... hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Fred Herrmann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mary Rosenau

(Address) 1906 N. Patterson Park Ave

MAY 19 1929 HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1929

17 I HEREBY CERTIFY, That I attended deceased from May 15 1929 to May 17 1929, that I last saw her alive on May 17 1929, and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

1. Strang Inf Hernia

2. Gen Peritonitis

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Pulmonary oedema from Cardiac Failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 15/29

Was there an autopsy? Yes

What test confirmed diagnosis? Hist. Phy. Oper. Autop

(Signed) K. Hyman M. D.

19 (Address) Sinai Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ln. London Park

DATE OF BURIAL 5 22 1929

20 UNDERTAKER H. A. Cook

ADDRESS 1247 Cook

B—WRITE PLAINLY, WITH UNFADING INK. This certificate should be filled out in accordance with the instructions and information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46087

CERTIFICATE OF DEATH.

90 E 46087

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5503 Pilgrim Rd ST. 27-43 WARD

2-FULL NAME Mary F. C. Spear

(a) RESIDENCE NO. 5503 Pilgrim Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): ~~Single~~

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Widowed

6 DATE OF BIRTH (month, day, and year): Mch 9. 1849

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
80	2	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: William V. Faroler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Mary Cooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Wm M. Spear

(Address) 2008 N. Mary

MAY 19 1929 T. HANSON JONES, M.D. Registrar

By Kelly

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 18. 1929

17 I HEREBY CERTIFY, That I attended deceased from May 17, 1929, to May 18, 1929, that I last saw h[illegible] alive on May 17, 1929, and that death occurred, on the date stated above, at 12.20 m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jacob Frahm, M. D.

5/18. 1929 (Address) 1823 N. Mad. St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: May 21 1929

20 UNDERTAKER: Wm Cook — ADDRESS: 1317 N. Paca

WRITE PLAINLY, with pen and ink. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 46088

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 46088

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1884 St.Paul St. St. 12-19 Ward)

2-FULL NAME Harry C.Mathews.

(a) RESIDENCE NO. 1884 St.Paul St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed or divorced, HUSBAND of Edith Mathews.

6 DATE OF BIRTH (month, day, and year) November 14, 1882

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	46	6	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Engineer.
(b) General nature of industry, business, or establishment in which employed (or employer) Pa.R.R.Co.
(c) Name of employer

9 BIRTHPLACE (city or town) Pennsylvania.
(State or country)

PARENTS

10 NAME OF FATHER Alexander C.Mathews.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Philadelphia, Pa.

12 MAIDEN NAME OF MOTHER Garcia S.Hancock.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland.

14 Informant Garcia S.Gorman.
(Address) Philadelphia, Pa.

15 Filed MAY 19 1929 C. HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Myocardial Insufficiency.
Acute dilatation of the Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) [illegible], M. D.

5/19. 1929 (Address) 1017 S.Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Glenwood Camden Co N.J.

DATE OF BURIAL 5/19 1929

20 UNDERTAKER W.M. Cook

ADDRESS 32 E. Pratt

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 46089

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

10-062

E 46089

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1724 Johnsen ST. 24-24 WARD)

2-FULL NAME Albert Edward Greenholtz

(a) RESIDENCE NO. 1724 Johnsen St ST.; WARD

(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 28—1927

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	11.	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Fred'k E. Greenholtz

11 BIRTHPLACE OF FATHER (city or town) Carrl Co (State or country) Maryland

12 MAIDEN NAME OF MOTHER Bertha A. Hamlet

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Maryland

14 Informant Fred'k E. Greenholtz (Address) 1724 Johnsen St

15 [illegible] 19 1929 C. HARRISON JONES, M. D. Registrar

Per [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 11, 1929, to May 18, 1929, that I last saw h[illegible] alive on May 18, 1929, and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia Acute

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. [illegible] Brown M. D.

19 29 (Address) 1 6 Hamilton Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem.

DATE OF BURIAL 5/20 19 29

20 UNDERTAKER Josiah Syfer

ADDRESS 1600 W. Wall

mation should be carefully supplied. AGE should be stated EXACTLY. If unknown, approximate. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46090

CERTIFICATE OF DEATH

17° E 46090

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Custom House. St., 11-26 Ward)

2-FULL NAME Paul E. Birkmeyer.

(a) RESIDENCE NO. 8 N. Poppleton St. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 51 yrs. 5 mos. 20 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) November 17, 1877.

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	51	5	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Messenger
(b) General nature of industry, business, or establishment in which employed (or employer) Custom House.
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md
(State or country)

PARENTS

10 NAME OF FATHER Willian Birkmeyer.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany.

12 MAIDEN NAME OF MOTHER Rebeca Granner.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland.

14 Informant Mrs. John E. Stansbury. (sister)
(Address) 2284 N. Monroe St.

15 Filed ..... 19 C. HAMPSON JONES, M. D. Registrar
MAY 19 1929
Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Pistol shot through the Heart.
Suicide.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry.

(Signed) [signature], M. D.

5/18. 1929 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem — DATE OF BURIAL 5/20/29

20 UNDERTAKER Harry A Witzke — ADDRESS 153 W Lombard St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 46091 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

12 D E 46091

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Women's Hospital

CITY OF BALTIMORE: (No. 14-20 ST., WARD)

2-FULL NAME Mrs Florence E. Shipley

(a) RESIDENCE NO. 1307 Linden Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr David W Shipley

6 DATE OF BIRTH (month, day, and year) Sept 13, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	8	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress 069

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Fairbury Md

PARENTS

10 NAME OF FATHER Abraham Lester

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Teresia Hahn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Mrs. Ella Claggett

(Address) Miami, Fla

15 C. HAMPSON JONES, M. D. Registrar

16 Per

MAY 19 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 19 29

17 I HEREBY CERTIFY, That I attended deceased from May 9, 1929, to May 18, 1929, that I last saw her alive on May 18, 1929, and that death occurred, on the date stated above, at 5:22 A m.

The CAUSE OF DEATH* was as follows: Carcinomatosis and Cachexia.

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Carcinoma pancreatitis

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) Chas F Hardyer, M. D.

5/18/29 (Address) Women's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury M E Cem. Reisterstown Md — DATE OF BURIAL: 5/20 1929

20 UNDERTAKER: Jos Block — ADDRESS: 1009 West Baltimore St

N. B.—WRITE PLAINLY, WITH INDELIBLE PENCIL OR PEN AND INK. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46092

CERTIFICATE OF DEATH

E 46092

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 548 (St.) Benningham Rd (WARD) 24-48

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Melissa Reynolds

(a) RESIDENCE NO. 548 (Usual place of abode) Benningham Rd WARD

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W	Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew J. Reynolds

6 DATE OF BIRTH (month, day, and year) June 25 1846

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
82	10	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework at home

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Talbot Co Maryland

PARENTS

10 NAME OF FATHER John H Wales

11 BIRTHPLACE OF FATHER (city or town) (State or country) Talbot Co Maryland

12 MAIDEN NAME OF MOTHER Irene Cochey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Talbot Co Maryland

14 Informant Miss Annie L. Probert

(Address) 548 Benningham Rd

15 Filed MAY 19 1929 C. H. HANDOOR JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 1929

17 I HEREBY CERTIFY, That I attended deceased from April 2 1929, to May 16 1929, that I last saw h alive on May 16 1929 and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Nephritis.

Pneumonia (duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Myocarditis (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas H Hollman, M. D.

May 18 1929 (Address) 1 W 34th

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Olivet Cemetery St. Michaels Md	May 20 1929
20 UNDERTAKER J. John F. Denny	ADDRESS 715 Light St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAY 19 1929

Spec.—1-10-21—M&T—1500 Blks.

E 46093

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

01-001

E 46093

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 650 W. Barre ST. 27-36 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Claymoore Brooks

(a) RESIDENCE NO. 650 W Barre ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. 4 mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Col

5 Single, Married, Widowed, or Divorced. (write the word) —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 23 1928

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
—	4	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Pleasant Brooks

11 BIRTHPLACE OF FATHER (city or town) Brookyln
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Alsup

13 BIRTHPLACE OF MOTHER (city or town) Scotch Bluff
(State or country) Virginia

14 Informant Margaret Brooks
(Address) 650 W Barre

Filed MAY 19 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1929

17

I HEREBY CERTIFY, That I attended deceased from May 7 1929 to May 17 1929 that I last saw h[illegible] alive on May 16 1929 and that death occurred, on the date stated above, at 1:30 p. m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) — yrs. — mos 11 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Dan Drennen M. D.

17 1929 (Address) 1[illegible] W Lee

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Williams Cemetery Baltimore

DATE OF BURIAL May 19 1929

20 UNDERTAKER Walter B. Speigh

ADDRESS Fairfield Md

N. B.—WHITE paper should be used. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46094

CERTIFICATE OF DEATH

× 90 E 46094

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1808 N. Calvert St. St., 12-14 Ward)

2-FULL NAME Jerome Anderson Wilcox.

(a) RESIDENCE NO. Stonington, Conn. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred En route ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) November 14, 1878

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	50	5	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Advertising man.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Stonington, Conn.
(State or country)

PARENTS

10 NAME OF FATHER Joseph B. Wilcox.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Philadelphia. Pa.

12 MAIDEN NAME OF MOTHER Margaret Marritt.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Stonington, Conn.

14 Informant Benj. T. Wilcox. (brother)
(Address) 65 John St. New York.

15 Filed MAY 19 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.
Acute dilatation of the Heart

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) ..... M. D.

5/19. 1929 (Address 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Stonington Conn	May 19 29
20 UNDERTAKER Edward Johnson Co	ADDRESS Balto.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46095

CERTIFICATE OF DEATH

90

E 46095

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Mount Hope Retreat ST., 28 WARD)

2—FULL NAME Thomas Rutt

(a) RESIDENCE NO. Mount Hope Retreat ST., 28 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. 0 mos. 0 ds. How long in U. S., if foreign birth? —yrs. —mos. —ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of X

6 DATE OF BIRTH (month, day, and year) March 19-1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
72	0	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Richard Rutt

11 BIRTHPLACE OF FATHER (city or town) Isle of Jersey
(State or country) England

12 MAIDEN NAME OF MOTHER Margaret Ann Callin

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Somerset Co Md

14

Informant Records of Mt Hope Retreat

(Address) Mt Hope Md

15

Filed MAY 19 1929 H. A. SOPER JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1929.

17

I HEREBY CERTIFY, That I attended deceased from May 1890, to , 19 ,

that I last saw him alive on May 18th, 1929

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Paralysis Focal Chr. Myoconsti & Arteria Sclerosi - abt (duration) 1 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Terminal Dementia (duration) 44 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Baltimore Md

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Frank J Flannery, M. D.

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	May 20 1929.
20 UNDERTAKER	ADDRESS
Stewart & Co	Balto

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 46096

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

105 E 46096

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 925 E Preston ST. 10-14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Noethen

(a) RESIDENCE NO. 925 E Preston ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice Noethen

6 DATE OF BIRTH (month, day, and year) Aug 23 1874

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
54	8 9	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Clothing Cutter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer 050

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Chas H. Noethen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hamburg Germany

12 MAIDEN NAME OF MOTHER Rosana Hugel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Chas H. Noethen

(Address) 1602 N Milton Ave

15 [illegible] 19 [illegible] HAMILTON JONES, M. D. Registrar

MAY 19 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1929

17 I HEREBY CERTIFY, That I attended deceased from Mar 21, 1929, to May 17, 1929, that I last saw h[illegible] alive on May 17, 1929, and that death occurred, on the date stated above, at 10 55 P m.

The CAUSE OF DEATH* was as follows:

Asthma

(duration) Continuous yrs. mos. ds.

CONTRIBUTORY (Secondary) Continuous

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Typical

(Signed) Wm T Seabury M. D.

5/18, 1929 (Address) 636 Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Baltimore Cemetery — DATE OF BURIAL May 20 1929

20 UNDERTAKER Henry Sander & Sons Inc — ADDRESS Baltimore St & Broadway

mation should be carefully supplied. AGE
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 96097
22445-6

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46097

CERTIFICATE OF DEATH.

135

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. 19-27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Levin Holland

(a) RESIDENCE No. 1400 W Lexington ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Johnson

6 DATE OF BIRTH (month, day, and year) 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Wm

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Dix

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant (Address) Records JOHNS HOPKINS HOSPITAL

15 Filed MAY 19 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1929

17 I HEREBY CERTIFY, That I attended deceased from April 16, 1929, to May 18, 1929, that I last saw him alive on May 15th, 1929, and that death occurred, on the date stated above, at 10:30 P m.

The CAUSE OF DEATH* was as follows:

Benign Prostatic Hypertrophy.

(duration) 2 yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Uraemia; pyelonephritis.

(duration) 6 yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Edward A Jamer M. D.

, 19 (Address) John Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Hill, Md DATE OF BURIAL 5 20 1929

20 UNDERTAKER H. C. Cook ADDRESS 1217 E Fayette

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 46098

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 46098

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 9 W. West ST. 23-31 (WARD)

2—FULL NAME Annie Lawler

(a) RESIDENCE No. 9 W. West ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1864

7 AGE — Years: 65 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER James Lawler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland.

12 MAIDEN NAME OF MOTHER Mary Purcell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland.

14 Informant (Address): Grace Lear 9 W West St

15 [illegible] G. HAMPSON JONES, M. D. Registrar

Per [illegible]

MAY 20 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16 19 29

17 I HEREBY CERTIFY, That I attended deceased from May 16, 19 29, to May 16, 19 29

that I last saw her alive on May 16, 19 29

and that death occurred, on the date stated above, at 145 p m.

The CAUSE OF DEATH* was as follows:

Acute edema of Lungs

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. L. Lichtenberg M. D.

5/14 19 29 (Address) 22 W Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Vincents Cemetery — DATE OF BURIAL: May 20 19 29

20 UNDERTAKER: Fred A. Hamerstrom — ADDRESS: 703 Hamm

I.—MAKE ENTRIES with ink. Use typewriter if possible. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46099

CERTIFICATE OF DEATH

X 111-002

E 46099

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Md. Gen. Hospital St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Stoner

(a) RESIDENCE NO. Westminster Md St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 9 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elsie May Stoner

6 DATE OF BIRTH (month, day, and year): Oct. 6 1874

7 AGE — Years: 50 Months: 7 Days: 13 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Md.

(State or country): Westminster

PARENTS

10 NAME OF FATHER: Charles Stoner

11 BIRTHPLACE OF FATHER (City or town): Md.

(State or country)

12 MAIDEN NAME OF MOTHER: Virginia Shaw

13 BIRTHPLACE OF MOTHER (city or town): Md

(State or country)

14 Informant: Hosp. Record

(Address)

Filed MAY 20 1929 19 G. HAMPSON JONES, M. D.

Supt.

For KRP

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 19 19 29

17 I HEREBY CERTIFY, That I attended deceased from 5-10, 19 29, to 5-19, 19 29, that I last saw h. alive on 5-19, 19 29 and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Perforated Duodenal ulcer

(duration) yrs. mos. 11 ds.

CONTRIBUTORY (Secondary): Cardiac Decompensation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? yes Date of 5.10.29

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. Kerpelmeier, M. D.

5/19, 19 29 (Address) Md General Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Westminster — Date of Burial: 5/23 19 29

20 UNDERTAKER: H. Bankard Sr. — ADDRESS: Westminster

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 46100 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 46100

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital ST. 14-20 WARD)

2-FULL NAME Mrs Anna Mc Guinn

(a) RESIDENCE NO. 1911 Division ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Warner T. McGuinn

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	64?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Husband (Address) Warner T. McGuinn 1911 Division

15 Filed MAY 20 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1929

17 I HEREBY CERTIFY, That I attended deceased from Apr 26, 1929, to May 17, 1929, that I last saw h[illegible] alive on May 17, 1929, and that death occurred, on the date stated above, at 4 05 P m.

The CAUSE OF DEATH* was as follows:

Cardiac Decompensation

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Dementia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) C. H. Jackson, M. D.

5/17/1929 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lamet

DATE OF BURIAL 5/20/1929

20 UNDERTAKER Mrs. George H. Holland

ADDRESS 1631 Druid

mation should be carefully supplied. AGE should be stated [illegible]
CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46101

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

117

E 46101

REGISTERED NO.

1—PLACE OF DEATH St Josephs Hospital

CITY OF BALTIMORE: (No. Augustus Jackson ST. 1622 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Augustus Jackson

(a) RESIDENCE NO. 1120 N. Stricker St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of G. Helen Jackson

6 DATE OF BIRTH (month, day, and year) ? 1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant G. Helen Jackson

(Address) 1120 N. Stricker St

15 E. HANSON JONES, M. D. Registrar

MAY 20 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-17-29

17

I HEREBY CERTIFY, That I attended deceased from 5-15-29, 19, to 5-17-29, 19, that I last saw h alive on 5-17-29, 19, and that death occurred, on the date stated above, at 9:10 P. m.

The CAUSE OF DEATH* was as follows:

Ruptured appendicitis c
general peritonitis

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 7-15-29

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. E. Lemmon, M. D.

, 19 (Address) St Josephs Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	5/20/29
20 UNDERTAKER	ADDRESS
Geo. H. Holland	1631 Druid Hill

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46102 ✓-00 37 E 46102

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST. 1726 E.B.A. WARD)

2—FULL NAME Helen Grant

(a) RESIDENCE NO. 746 Pierce st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1915

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	14			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School-girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Alabama

PARENTS

10 NAME OF FATHER Thomas Grant

11 BIRTHPLACE OF FATHER (city or town) (State or country) Alabama

12 MAIDEN NAME OF MOTHER Emma Herron

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Alabama

14 Informant Hospital Records

(Address)

15 Filed MAY 20 1929 HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 16, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1929, to May 16, 1929, that I last saw her alive on May 16, 1929 and that death occurred, on the date stated above, at 12 noon m.

The CAUSE OF DEATH* was as follows:

Polyserositis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical and autopsy

(Signed) Henry C. Smith M. D.

5-17 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	5-20 1929
20 UNDERTAKER	ADDRESS
Dame & Eaton	Balto

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46103

CERTIFICATE OF DEATH

E 46103

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 1005 Bantalou St., (16-68 Ward) 90

2-FULL NAME John H. Hardingham Sr

(a) RESIDENCE NO. 1005 Bantalou St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 60 mos. — dys. — How long in U. S., if of foreign birth? yrs. mos. dys.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nellie

6 DATE OF BIRTH (month, day, and year) Mar 16 1856

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	73	2	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Mail Clerk
(b) General nature of industry, business, or establishment in which employed (or employer) U. S. P. O.
(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant (Address) John H. Hardingham 1005 Bantalou St

15 Filed MAY 20 1929 16 LAWSON JONES, M. D. Registrar

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) May 16th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Regular Physician, M. D.

May 16th 29 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL 5/20/1929

20 UNDERTAKER Geo. Rebert & Son — ADDRESS 2503 Edmondson Ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46104

CERTIFICATE OF DEATH

E 46104

REGISTRATION No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 226 S. Eutaw St., 10-69 Ward)

2-FULL NAME Samuel Skippers

(a) RESIDENCE NO. 2115 W. Lexington St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 69 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Skippers

6 DATE OF BIRTH (month, day, and year) Nov. 22 - 1859

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	69	5	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Boiler maker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) England

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) England

14 Informant Miss Clara Skippers
(Address) 2115 W. Lexington St

15 Filed ....., 19.... [illegible] Registrar

MAY 201929

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Pulmonary Tuberculosis

..... (duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

..... (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Eugene Zeller M. D.

5/20, 1929 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	May 20 1929
20 UNDERTAKER George L. Ashton	ADDRESS 210 Eutaw

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46105

CERTIFICATE OF DEATH.

E 46105

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. W 1 Baltimore Gen'l Hosp ST. 19-28 WARD)

2-FULL NAME Mrs John Houck

(a) RESIDENCE No. 1836 Harlem Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, (Married) Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~: Mrs J Houck

6 DATE OF BIRTH (month, day, and year): Oct 7, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Frederick County

PARENTS

10 NAME OF FATHER: John Houck

11 BIRTHPLACE OF FATHER (city or town) (State or country): Frederick County

12 MAIDEN NAME OF MOTHER: Margaret Early

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Frederick Co

14 Informant: Alice Houck

(Address): 1836 Harlem Ave

15 C. HARRISON JONES, M. D.

19 Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/16/29 19

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1929, to May 16, 1929.

that I last saw him alive on May 16, 1929

and that death occurred, on the date stated above, at 11 30 Pm

The CAUSE OF DEATH* was as follows:

~~Chronic Nephritis (Uremia)~~

Hypertrophied Prostate

(duration) 2 yrs. 1 mos ds.

CONTRIBUTORY (Secondary) ~~Chronic Nephritis (Uremia)~~ arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 4/18/29

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Laboratory

(Signed) Benjamin Jamin, M. D.

19 (Address) West. Balto. Gen. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount

DATE OF BURIAL: 5/20/29

20 UNDERTAKER: Child Henry

ADDRESS: 2066 Orleans

MAY 20 1929

mation should be carefully supplied. Avoid words not clearly understood. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46106

CERTIFICATE OF DEATH

90

E 46106

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2812 Ruckert Av ST. 7-7-44 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frederick William Daus

(a) RESIDENCE NO. 2812 Ruckert Av ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lola Daus

6 DATE OF BIRTH (month, day, and year) Sept 16, 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	61	7 8	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker 003

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Maryland

PARENTS

10 NAME OF FATHER Frederick Daus

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Augusta Tollack

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Louis Aug Daus

(Address) 2812 Ruckert Ave

15 Filed ..... 19 ..... C. HARRISON JONES, M. D. Registrar

By .....

MAY 20 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18, 1929.

17 I HEREBY CERTIFY, That I attended deceased from Nov. 28, 19.., to May 18, 1929.

that I last saw h.. alive on May 18 19 29

and that death occurred, on the date stated above, at 9.30a m.

The CAUSE OF DEATH* was as follows:

Hypertensive Cardio Vascular Disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Louis Krauss, M. D.

, 19 (Address) 20 E Lexington St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Emmanuel Cemetery	May 20 1929

20 UNDERTAKER Louis H. Kemann ADDRESS 22 S. Broadway

OF DEATH in plain terms, so that it may be properly classified. Each statement of occupation is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46107

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46107

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hospitals STREET) (WARD)

2—FULL NAME Samuel Goldshaw

(a) RESIDENCE NO. 127 E Lidling St WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 3-7-1895

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Thomas Goldshaw

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Sara Kennedy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Penna

14 Informant: Hospital Records

(Address)

15 Filed: ....., 19.... Registrar

HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/15-29

17 I HEREBY CERTIFY, That I attended deceased from 5-13, 1929, to 5/18, 1929, that I last saw h[illegible] alive on 5/18, 1929 and that death occurred, on the date stated above, at 11.40 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Laboratorial

(Signed) Henry C. Smith, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: 5-21-1929

20 UNDERTAKER: [illegible] Cook — ADDRESS: 1217 E Lanvale

OF DEATH in plain terms, so that it may be properly classified. important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 46108

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46108

CERTIFICATE OF DEATH

90

22-33

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 736 Light St. St.) Ward)

2-FULL NAME George C. Yingling.

(a) RESIDENCE NO. 736 Light St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. --- mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White.	Married.

5a If married, widowed, or divorced, HUSBAND of (or WIFE of) Geneva Yingling.

6 DATE OF BIRTH (month, day, and year) September 1, 1879

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	49	8	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Westminster, Md
(State or country)

PARENTS

10 NAME OF FATHER George Yingling.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Mary ------

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Geneva Yingling. (wife)
(Address) 736 Light St.

15 Filed ..... 19.. C. HARRISON JONES, Registrar.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Mitral Stenosis.
Organic disease of the Heart.
(duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary)
(duration) ..yrs. ..mos. ..ds.

18 Where was disease contracted if not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? Inquiry
(Signed) [signature] M. D.
5/20 1929 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL [illegible] Odd

DATE OF BURIAL 5/21/29

20 UNDERTAKER [illegible]

ADDRESS [illegible] Paul

MAY 20 1929

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every question should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46109

HEALTH DEPARTMENT—CITY OF BALTIMORE

58-002

E 46109

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 26 N. Smallwood ST. 20-69 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Joseph B Woolen

(a) RESIDENCE NO. 26 N Smallwood ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 1 mos. 0 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white.	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary P. Woolen.

6 DATE OF BIRTH (month, day, and year) April 18th 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64.	1	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Helper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B. & O. R. R.

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John Woolen.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Ann M. Lane.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mary P. Woolen.

(Address) 26 N Smallwood St.

MAY 20 1929

H. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18th 1929.

17 I HEREBY CERTIFY, That I attended deceased from May 4, 1929, to May 18, 1929, that I last saw him alive on May 18 1929 and that death occurred, on the date stated above, at 10 30 P. m.

The CAUSE OF DEATH* was as follows:

Secondary Anemia

(duration) yrs. 2 mos. 18 ds.

CONTRIBUTORY (Secondary) Renal Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) Edgar V. Jones M. D.

, 19 (Address) 1500 Hollins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	May 21 '29
20 UNDERTAKER	ADDRESS
D. Tim Cowan & Co	[illegible]

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46110

CERTIFICATE OF DEATH

38

E 46110

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Balto. City Hosp ST. 5-8 WARD)

2—FULL NAME John Ray

(a) RESIDENCE NO. 319 Colvin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. Life ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) — (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) — (State or country)

14 Informant Hospital Record

(Address)

15 Filed MAY 20 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/14/29

17

I HEREBY CERTIFY, That I attended deceased from 2/27, 1929, to 5/14, 1929

that I last saw h.. alive on 5/14, 1929

and that death occurred, on the date stated above, at 9:20 A m.

The CAUSE OF DEATH* was as follows:

Aneurysm of thoracic aorta

Aneurysm of Left popliteal artery

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Rupture of thoracic aneurysm (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. A. Lumpkin, M. D.

5/14, 1929 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cem

DATE OF BURIAL 5-20 1929

20 UNDERTAKER Byron Knight

ADDRESS 218 McCulloh St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 46111

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

161-001

REGISTERED No. E 46111

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1028 Sterling St., 10-14 Ward)

2-FULL NAME James Crosby Jr

(a) RESIDENCE NO. 1028 Sterling St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Black	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 16/29

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) none
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER James Crosby

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore

12 MAIDEN NAME OF MOTHER Beatrice R. Harris

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore

14 Informant Beatrice Crosby
(Address) 1028 Sterling St

15 Filed ... E. HAMPSON JONES, M. D.
Registrar

MAY 20 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 15 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Premature

about 7 hours gestation

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY
(Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Carter M. D.

5-18 1929 (Address) 508 E Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Asbury Cem

DATE OF BURIAL: 5-20 1929

20 UNDERTAKER: Byron & Wright 1218 N. Eutaw St

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ... tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46112

CERTIFICATE OF DEATH

E 46112

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2902 Strathmore St. Ward 24 Hamilton)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary E. Duvall

(a) RESIDENCE NO. 2902 Strathmore Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 21 1905

7 AGE — Years: 23 | Months: 10 | Days: 27 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stenographer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Johns Hopkins University

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: D. Oden Duvall

11 BIRTHPLACE OF FATHER (city or town) (State or country): A. A. Co. Maryland

12 MAIDEN NAME OF MOTHER: Carrie E. Ephraett

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Co. Md.

14 Informant: Carrie E. Fries

(Address) 2902 Strathmore ave.

15 C. HAMPSON JONES, M. D. Registrar

MAY 20 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 18th 1929

17 I HEREBY CERTIFY, That I attended deceased from 4-1-29 to 5-18-29, 19..., that I last saw h... alive on 5-18-29, and that death occurred, on the date stated above, at 7:15 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Fulminating

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Sputum

(Signed) Fred Bartlett M. D.

May 19 1929 (Address) 100 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	May 21 1929
20 UNDERTAKER	ADDRESS
Frederick Loeffler and Son	Fullerton

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 46113 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90

E 46113
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 2837 (Street) Woodbrook Ave (13-59 WARD)

2-FULL NAME George W. Harryman

(a) RESIDENCE No. 2837 Woodbrook ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
~~or) WIFE of~~ Minnie Harryman

6 DATE OF BIRTH (month, day, and year) Nov. 6 1877

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hotel Proprietor

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Thomas D. Harryman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary E Bailey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Frank E. Harryman

(Address) 2837 Woodbrook Ave

15 MAY 20 1929 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1928 to May 19, 1929.

that I last saw him alive on May 18, 1929.

and that death occurred, on the date stated above, at 2:5 a.m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac dilatation
Hypostatic congestion

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary) Mitral regurgitation
~~duration~~ yrs. ~~mos~~ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. L. Finney M. D.

5-20-29 (Address) 682 Park Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL May 21 1929

20 UNDERTAKER Josiah Syfer — ADDRESS 16 or N North Ave

BEFORE filling in, be careful that CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46114 — **CERTIFICATE OF DEATH** — **E 46114**

1—PLACE OF DEATH

REGISTERED NO. 2331

CITY OF BALTIMORE: (No. 934 Hanover Street ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Calogero Maida

(a) RESIDENCE NO. 934 Hanover Street ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if foreign birth? 32 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Josephine Maida

6 DATE OF BIRTH (month, day, and year) July 12th 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	10	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoe Laster

(b) General nature of industry, business, or establishment in which employed (or employer) Proprietor

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Francesco Maida

11 BIRTHPLACE OF FATHER (city or town) Italy (State or country)

12 MAIDEN NAME OF MOTHER Mariana Samperi

13 BIRTHPLACE OF MOTHER (city or town) Italy (State or country)

14 Informant Frank Prescimone

(Address) 911 E. Lexington Street

15 [illegible] C. HAMSON JONES, M. D. Registrar

AY 20 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1929

17 I HEREBY CERTIFY, That I attended deceased from Apr. 1st, 1929, to May 16, 1929, that I last saw him alive on May 16, 1929 and that death occurred, on the date stated above, at 430 p m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Central embolism

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) B Kadin, M. D.

, 19 (Address) 2306 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	May 21 1929

20 UNDERTAKER Frank V. Pistorio — ADDRESS 2815 E. Baltimore

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46115

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 E 46115

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. So Balto Gen H ST. 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Boy Dietz

(a) RESIDENCE NO. 1222 Mulberry ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Premature

6 DATE OF BIRTH (month, day, and year) 5/17/29

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 10 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Premature

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md (State or country)

PARENTS

10 NAME OF FATHER Chas Dietz

11 BIRTHPLACE OF FATHER (city or town) Balto, (State or country)

12 MAIDEN NAME OF MOTHER Jennie Roth

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Hospital Records

(Address)

15 Filed MAY 20 1929 J. C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/17/29

17

I HEREBY CERTIFY, That I attended deceased from 5/17, 1929, to 5/17, 1929, that I last saw him alive on 5/17, 1929 and that death occurred, on the date stated above, at 10:10 p m.

The CAUSE OF DEATH* was as follows:

Premature Separation of Placenta & Cystic

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Prematurity

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? In utero

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. Schwalbach M. D.

5/17, 1929 (Address) Balto Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

MAY 18 1929

Commissioner of Health.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

46116 E 46116

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 925 St. Paul St. St. 11-15 Ward)

2-FULL NAME William R. Mason.

(a) RESIDENCE NO. 927 St. Paul St. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. [redacted] How long in U. S., if of foreign birth? 7 [redacted] ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, [redacted] HUSBAND of [redacted] Ida B. Mason.

6 DATE OF BIRTH (month, day, and year) June 19, 1888.

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	45	11	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Salesman.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town)
(State or country) Scotland.

PARENTS

10 NAME OF FATHER James Mason.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Scotland

12 MAIDEN NAME OF MOTHER Margaret Wilson.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Scotland.

14 Informant Ida B. Mason. (wife)
(Address) 927 St. Paul St.

15 [illegible] 19 C. HAMPSON JONES M. D. Registrar

MAY 20 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18, 1929. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull.
Jumped from third story window.
Suicide while temporarily deranged.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto Feinandt, M. D.

5/20, 1929 (Address) 1017 E. Charles st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baptist Cemetery — DATE OF BURIAL: May 21 1929

20 UNDERTAKER: D. Elkins & Son — ADDRESS: Jones Falls

—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT—Any erasure or mutilation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46117

CERTIFICATE OF DEATH

74-001

E 46117

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 1410 W. Mulberry St. 14-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edna Dickerson

(a) RESIDENCE NO. 1410 W. Mulberry St., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Dickerson

6 DATE OF BIRTH (month, day, and year) Sept-8-1888

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40	8	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Perry Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Charlotte Butler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant James Dickerson

(Address) 1410 W. Mulberry St

15 Filed MAY 20 1929 Harry Jones M. D. Registrar

MAY 20 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17/29

17 I HEREBY CERTIFY, That I attended deceased from May 16, 1929, to May 17, 1929, that I last saw h[illegible] alive on May 17, 1929 and that death occurred, on the date stated above, at 6:20 p m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

5/20, 1929 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	May 20 1929
20 UNDERTAKER	ADDRESS
Samuel Dougherty & Bro	[illegible]

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

-281

HEALTH DEPARTMENT—CITY OF BALTIMORE

46118

CERTIFICATE OF DEATH.

100-001

E 46118

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 1724 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Slemich

(a) RESIDENCE NO. 5-29 Lambert ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 30 1925

7 AGE: Years 3 Months 5 Days 17 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md -

PARENTS

10 NAME OF FATHER Archie Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Nellie Slemich

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Friends. (Address)

15 [illegible] HAMPSON JONES, M. D. Registrar

MAY 20 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17 1929

17

I HEREBY CERTIFY, That I attended deceased from May 13, 1929, to May 17, 1929, that I last saw her alive on May 17, 1929, and that death occurred, on the date stated above, at 12 40 p m.

The CAUSE OF DEATH* was as follows:

Bilateral Bronchopneumonia
Bilateral otitis media

(duration) ... yrs. ... mos 15 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of ...

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary — DATE OF BURIAL: May 21 29

20 UNDERTAKER: Mrs. R. G. Elliott — ADDRESS: 216 Eastern

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46119

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 46119

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) 1739 (ST.) Carswell (WARD) 9-46

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rosa M Lambright

(a) RESIDENCE NO. 1739 (ST.) Carswell (WARD)
(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of John Lambright

6 DATE OF BIRTH (month, day, and year) Oct. 10, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	7	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 03

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Md.

PARENTS

10 NAME OF FATHER August Henley

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country)

12 MAIDEN NAME OF MOTHER Louisa Sauers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Miss Louisa Lambright

(Address) 1739 Carswell St.

15 [illegible] Registrar

MAY 20 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 14, 1929, to May 18, 1929, that I last saw h.er alive on May 18, 1929 and that death occurred, on the date stated above, at 7 45 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Nephritis

Chr. Myo-endo-carditis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Evidence

(Signed) Wm. B. Dyer M. D.

, 19 (Address) 2804 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	May 21st 1929
20 UNDERTAKER	ADDRESS
Geo. L. Schilling & Sons	1126 E Monument

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

129 E 46120

E 46120

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1925 Dukeland ST.) 15-68 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sarah Jane Essig

(a) RESIDENCE NO. 1926 Dukeland ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 77 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced (or) WIFE of: J Fredrick Essig

6 DATE OF BIRTH (month, day, and year): Feby 16th 1852

7 AGE: Years 77 | Months 3 | Days 3 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John B. Hofmann

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Sarah E Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Howard Co Md

14 Informant: Mary E Wyman

(Address): 1425 Dukeland ave

15 Filed MAY 20 1929 REGISTRAR OF VITAL STATISTICS. Registrar. Cook

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5-19-29

17 I HEREBY CERTIFY, That I attended deceased from Feb. 5, 1928, to May 19, 1929, that I last saw h[illegible] alive on May 18, 1929 and that death occurred, on the date stated above, at 7:[illegible]a m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic myocarditis.

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature] M. D.

5/19/29 (Address) 2757 W. North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	May 22nd 1929
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 Hanover st

IMPORTANT—Fill in all items. Write plainly. Use ink. Do not abbreviate. Write DEATH in plain terms, so that it may be properly classified. Exact statement of cause is important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Fred Koenig

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46121

CERTIFICATE OF DEATH.

REGISTERED NO. **E 46121**

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No. ..... ST. 1-2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fred Koenig

(a) RESIDENCE NO. 124 S. Potomac ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Short Koenig

6 DATE OF BIRTH (month, day, and year): Jan 22 1881

7 AGE — Years: 48 — Months: 3 — Days: 26. — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Contractor & Builder

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Phila. Pa.

PARENTS

10 NAME OF FATHER: Fred Koenig

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Wilhelmina Alber

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. Koenig
(Address) 124 S. Potomac St

15 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 18 1929

17

I HEREBY CERTIFY, That I attended deceased from May 14, 1929, to May 18, 1929,

that I last saw him alive on May 17, 1929,

and that death occurred, on the date stated above, at 8:30 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Lung

(duration) 1 yrs. 6 mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) M J Cohen, M. D.

, 19 (Address) Sinai Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional spaces.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem

DATE OF BURIAL: 5/21/1929

20 UNDERTAKER: J J Moran

ADDRESS 3000 E Oriole

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAY 20 1929

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46122

CERTIFICATE OF DEATH.

E 46122

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital ST. 1424 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Daniel Ryan

(a) RESIDENCE NO. Provident Hospital ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Mar

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Day Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address)

15 [illegible] C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-16-1929

17 I HEREBY CERTIFY, That I attended deceased from 5-13-1929, to 5-16-1929, that I last saw h alive on 5-16-1929, and that death occurred, on the date stated above, at 12:05 a m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart disease.

Dropic ulcus leg

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. C. Jackson, M. D.

5/16, 1929 (Address) 6007 Arlington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

MAY 20 1929

MAY 20 1929

Commissioner of Health

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 46123

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46123

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1761 Montpelier ST., 9-4½ (WARD)

2-FULL NAME Catherine Gormley.

(a) RESIDENCE NO. 1761 Montpelier ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE White

5 Single, ~~Married~~, Widowed, ~~or Divorced~~, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) August 15 1878.

7 AGE Years 50 Months 9 Days 3 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER M. Gormley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Mrs. Francis Rivers

(Address) 1761 Montpelier St

15 19 C. HAMPSON JONES, M. D.

For Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1929, to May 18, 1929, that I last saw h[illegible] alive on May 18, 1929 and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Aortic Regurgitation

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Dropsy

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? At House

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) C. Hampson Jones, M. D.

May 21, 1929 (Address) 563 Hartford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Mount Calvary Cemetery. DATE OF BURIAL May 21. 1929

20 UNDERTAKER Geo. A. Ruth ADDRESS 1725 Hartford ave

W 201929

BLANK SHOULD BE CAREFULLY ANSWERED. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Blks.

20475

E 46124

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46124

CERTIFICATE OF DEATH. X 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. 9-9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joe Cimo

(a) RESIDENCE NO. Hastings Pa ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W.	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 8-10-25

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	9	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 000

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER James Cimo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Concepcion Castellanos

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 5 . 1928 . to May 19 . 1929 , that I last saw him alive on May 19 . 1929 , and that death occurred, on the date stated above, at 810 P m.

The CAUSE OF DEATH* was as follows:

nephrosis
(chronic nephritis)

(duration) yrs 18 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis

(Signed) J. C. Goodwin M. D.

May 20 1929 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hastings, Cambria Co. Pa

DATE OF BURIAL May 20 1929

20 UNDERTAKER Via Auto.

John F. Denny

ADDRESS 715 Leigh St

MAY 20 1929

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCC TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 46125

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46125

CERTIFICATE OF DEATH.

1-PLACE OF DEATH West Baltimore General Hosp

CITY OF BALTIMORE: (No. Baltimore Md ST. 15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby boy Bayarsky

(a) RESIDENCE No. 2537 Oswego Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White & Jewish

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): May 19-1929

7 AGE: Years | Months | Days: 1 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): West Baltimore Md. Hosp

PARENTS

10 NAME OF FATHER: Sal Bayarsky

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Ida Rasnick

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Sal Bayarsky

(Address) 2537 Oswego Ave

15 [illegible] 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 20 1929

17 I HEREBY CERTIFY, That I attended deceased from May 19, 1929, to May 20, 1929, that I last saw him alive on May 20, 1929, and that death occurred, on the date stated above, at 1 20 P. m.

The CAUSE OF DEATH* was as follows:

Premature infant

due to Placenta Previa

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

, 19 (Address) West Balto. Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Workmen Circle Cem

DATE OF BURIAL: 5-21-1929

20 UNDERTAKER: Jack Levin

ADDRESS: 1439 E Balto

MAY 20 1929

mation should be carefully supplied. Also state whether deceased was married, single or widowed. Exact statement of OCCUPA-CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 46126

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46126

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. W-7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William J. Emmart

(a) RESIDENCE NO. Pinto, Maryland St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 5 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: not obtainable

6 DATE OF BIRTH (month, day, and year): 1880

7 AGE: Years 49 Months Days IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): ?

(State or country): West Virginia

PARENTS

10 NAME OF FATHER: not obtainable

11 BIRTHPLACE OF FATHER (City or town): " ?

(State or country)

12 MAIDEN NAME OF MOTHER: not obtainable

13 BIRTHPLACE OF MOTHER (city or town): " "

(State or country)

14 Informant: Hospital Record

(Address)

15 Filed MAY 20 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/20/29 19

17 I HEREBY CERTIFY, That I attended deceased from 5/15/29, 19..., to 5/20/29, 19..., that I last saw him alive on 5/20/29, 19..., and that death occurred, on the date stated above, at 4 45 p. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ...yrs. ...mos. 3 ds.

CONTRIBUTORY (Secondary): Cardiac Failure

(duration) Sudden yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) J. S. Winstead, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cumberland, Md. Date of Burial: 5/20 1929

20 UNDERTAKER: H. W. Means & Son ADDRESS: 705 N. Calvert St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL DOCUMENT. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46127

CERTIFICATE OF DEATH.

E 46127

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2108 Lake Ave St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Ethelbert Infant T. Herbert Ft. Virginia Eckhardt

(a) Residence No. 2108 Lake Ave St., Ward.

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) May 19-1929

7-AGE. ....yrs. ....mos. ....ds.

If LESS than 1 day, 8 hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER, Herbert F Eckhardt

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Jamestown New York

12-MAIDEN NAME OF MOTHER, Ellen Virginia Cable

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Baltimore Md

14- (Informant) Ellen V. Cable

(Address) 2108 Lake Ave

15- C. HAMPSON JONES, M. D.

Registrar.

MAY 21 1929

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 20 1929

17- I HEREBY CERTIFY, That I attended deceased from May 19 1929 to May 20 1929

that I last saw her alive on May 19 1929

and that death occurred, on the date stated above, at 6 30 P. m.

The CAUSE OF DEATH* was as follows:

Prolonged labor

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) Chas Hubert M. D.

May 20 1929 (Address) Maple Ave & Belair Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Fellowship Cem.

DATE OF BURIAL. May 21, 19..

20-UNDERTAKER. John Burns Sons

ADDRESS Towson

Should be carefully supplied. Age should be stated. Error in statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46128

CERTIFICATE OF DEATH

73 ✓

E 46128

REGISTERED NO.

1—PLACE OF DEATH

BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE. (No. [illegible] ST. 17-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emma Lewis

(a) RESIDENCE NO. 713 W Dolphin ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Wid

5a If married, widowed, or divorced HUSBAND of (or) WIFE of not given

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Joest Gumby

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Eliza

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address) BALTIMORE CITY HOSPITALS

15 Date received MAY 21 1929 Registrar [illegible] M.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-18-29

17 I HEREBY CERTIFY, That I attended deceased from 3-17, 1929, to 5-18, 1929, that I last saw h alive on , 19 , and that death occurred, on the date stated above, at 5 30 A. m.

The CAUSE OF DEATH* was as follows:

Spastic paraplegia - Cystitis -

(duration) yrs 8 mos. ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no Physical Exam

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion — DATE OF BURIAL May 21 1929

20 UNDERTAKER John H. Trodden — ADDRESS 1027 Hanover Hill

OF DEATH in plain terms, so that it may be properly classified. Every statement of cause is important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46129

CERTIFICATE OF DEATH

90 E 46129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 285 N. Gay St. St. 14-20 Ward)

2-FULL NAME James J. Bailey. (C)

(a) RESIDENCE NO. 555 Pressman St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. ---mos.---ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Widower

5a If ~~MARRIED~~, widowed, or ~~DIVORCED~~ HUSBAND of ~~WIFE~~ of Rena Bailey. (C)

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	45	---	---	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Chauffeur.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Daniel J. Bailey. (C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Charity Clash. (C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland.

14 Informant Daniel J. Bailey. (C) son.
(Address) 555 Pressman St.

15 Filed ..... 19.... C. HAMPSON JONES, M. D. Registrar

MAY 21 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.
Acute dilatation of the Heart.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto K. Eminhardt, M. D.

5/20. 1929 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	May 22 1929
20 UNDERTAKER John H. Toadvine	ADDRESS 1027 Edmondson

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46130

CERTIFICATE OF DEATH.

117

E 46130

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital 16-22 WARD)

2-FULL NAME George Pankam

(a) RESIDENCE NO. 1423 E Winchester ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	col	Married

5a If married, widowed, or divorced (or) ~~WIFE~~ of Lucy Pankam

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter

(b) General nature of industry, business, or establishment in which employed (or employer) Saloon

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Lucy Pankam

(Address) 1429 E Winchester St

15 Filed MAY 21 1929 WILLIAM H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-18- 1929

17

I HEREBY CERTIFY, That I attended deceased from 5-10- , 1929, to 5-18- , 1929,

that I last saw h— alive on 5-18 , 1929,

and that death occurred, on the date stated above, at 1P m.

The CAUSE OF DEATH* was as follows:

Strangulated appendix
Ruptured
Acute peritonitis

(duration) yrs. 9 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 5/19/29

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) [illegible] M. D.

5/20, 1929 (Address) Community Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL: Mt Auburn Cem 5-21 1929

20 UNDERTAKER — ADDRESS: Daniel Easton 846 Mad

MATION should be Carefully supplied. Note should be taken of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46131 HEALTH DEPARTMENT—CITY OF BALTIMORE E 46131

CERTIFICATE OF DEATH

31

1—PLACE OF DEATH

REGISTERED NO. 17-12

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST. (If not in a hospital) WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Davis

(a) RESIDENCE NO. 527 Brune st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1914

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	15			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER John Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Sarah ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records

(Address)

Filed MAY 21 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 17, 1929

17

I HEREBY CERTIFY, That I attended deceased from Jan. 26, 1929, to May 17, 1929, that I last saw him alive on May 17, 1929 and that death occurred, on the date stated above, at 2.10 p. m.

The CAUSE OF DEATH* was as follows:

Cerebro Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Henry Smith, M. D.

5-17, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	5-21 1929
20 UNDERTAKER Daniel Eaton	ADDRESS 916 6a ave

Important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT CITY OF BALTIMORE

E 46132

CERTIFICATE OF DEATH.

182 E 46132

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) Druid Hill Park Lake St. 1923

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Tyler

(a) RESIDENCE NO. 80 E. Lexington St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Annie Tyler

6 DATE OF BIRTH (month, day, and year): 9/900

7 AGE: Years 29 Months Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town): Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER: Henry Tyler

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Md

12 MAIDEN NAME OF MOTHER: Annie Foster

13 BIRTHPLACE OF MOTHER (City or town)

(State or country) Md

14 Informant: Annie Tyler

(Address) 1106 Mosher St

15 Filed 19 Registrar

MAY 21 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-18 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to h death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) John H. Thomsen M. D.

(Coroner)

5/20, 1929 (Address) 2532 Roland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem Date of Burial May 21 1929

20 UNDERTAKER: Samuel Hensley ADDRESS 578 N. Bond

NOTE—WRITE PLAINLY with pen and ink. Use no abbreviations. Fill in all blanks with the information required. Question 18 should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks. Bessie Norton Coleman

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46133

CERTIFICATE OF DEATH

74-001

E 46133

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 948 W. Lexington ST. 16-26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Bessie Norton Coleman

(a) RESIDENCE NO. 948 W Lexington ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Col.	Wid

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Smith Coleman

6 DATE OF BIRTH (month, day, and year) June 17, 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
48 49		11	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) 041

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER George Norton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Sophia Byrd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Lewis Conlin

(Address) 948 W Lexington

15 Filed MAY 21 1926 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18 26

17 I HEREBY CERTIFY, That I attended deceased from May 12, 1926, to May 15, 1926, that I last saw h... alive on May 18, 1926 and that death occurred, on the date stated above, at 3 22 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Pulm. Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Norwood, M. D.

May 19, 1926 (Address) 907 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Lebanon Cemetery	May 22, 1926
20 UNDERTAKER Mrs Katie R Williams	ADDRESS 322 N Schroeder St

OF DEATH in plain terms, so that it may be properly classified. Many additional questions are important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46134

CERTIFICATE OF DEATH

100-001

E 46134

1—PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. So. Balto Gen Hosp WARD)

2—FULL NAME Warner Rainier

(a) RESIDENCE NO. 120 E. Giddings ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) aug 28. 1928

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		8	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto. md.

PARENTS

10 NAME OF FATHER Wm. L. Rainier

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Annie Haynie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Wm L. Rainier
(Address) 120 Gittings St.

15 Date received MAY 21 1929, 19 .....
Registrar

HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1929

17 I HEREBY CERTIFY, That I attended deceased from May 19, 1929, to May 19, 1929, that I last saw him alive on May 19, 1929 and that death occurred, on the date stated above, at 6.12 P.m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

..... (duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Unknown

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) William W. Chew, M. D.

, 19 (Address) So. Balto Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cem.	May 21 1929
20 UNDERTAKER Margaret A. Flynn	ADDRESS 1422 Light St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46135

CERTIFICATE OF DEATH

41 E 46135

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. Union Memorial Hospital ST 25-77 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Lenora Moore

(a) RESIDENCE NO. 4902 Pennington Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wid. of Jas. A. Moore

6 DATE OF BIRTH (month, day, and year): June 29th 1866

7 AGE — Years: 62 | Months: 9 10 | Days: 20 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Richmond, Virginia.

PARENTS

10 NAME OF FATHER: Robert T. Hancock

11 BIRTHPLACE OF FATHER (city or town) (State or country): Richmond Va.

12 MAIDEN NAME OF MOTHER: Lucy Jordan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Richmond Va.

14 Informant: Hospital Records.
(Address)

15 Filed MAY 21 1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/19/29

17 I HEREBY CERTIFY, That I attended deceased from April 16th, 1929, to May 19th, 1929, that I last saw her alive on May 19th, 1929 and that death occurred, on the date stated above, at 5.50 P m.

The CAUSE OF DEATH* was as follows:

Streptococcus Viridans Septicemia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. J. Geraghty, M. D.

5/19, 1929 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Richmond Va.

DATE OF BURIAL: May 22 1929

20 UNDERTAKER: Margaret E. Flynn

ADDRESS: 1422 Light

Be sure to give the information called for. Every item important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

46136 HEALTH DEPARTMENT—CITY OF BALTIMORE E 46136

CERTIFICATE OF DEATH. 129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital St. 6-4 WARD)

2-FULL NAME Mrs Dora Ayler Goren

(a) RESIDENCE NO. 107 N. Ann St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? 22 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Abraham Goren

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE: Years 56; Months —; Days —; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Mayer G. Engel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Alder R. —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: David Goren

(Address) 142 Jackson St

15 Filed MAY 21 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 21/29

17 I HEREBY CERTIFY, That I attended deceased from April 29, 1929, to May 21, 1929, that I last saw her alive on May 21, 1929, and that death occurred, on the date stated above, at 2:10 A m.

The CAUSE OF DEATH* was as follows:

Chronic diffuse Nephritis.

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood Chemistry

(Signed) Fredrick J. Wolf, M. D.

5-21, 1929 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Int Asmel — DATE OF BURIAL: 5/21 1929

20 UNDERTAKER: Jack Levin — ADDRESS 1439 Eutaw St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46137

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46137

CERTIFICATE OF DEATH

49

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1811 Linden ave ST. 14th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Aaron Pehr

(a) RESIDENCE NO. 1811 Linden ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if foreign birth 43 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of: Bettie Pehr

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: 68 — Months: — — Days: — — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Ladies Tailor

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Henie Pehr

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Mrs A. Pehr
(Address) 1811 Linden ave

15 Filed ..... 19 ..... H. HAMPSON JONES, M. D. Registrar

BY 211929 PAT RAM

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/19/29

17

I HEREBY CERTIFY, That I attended deceased from June, 1929, to May 19, 1929, that I last saw him alive on May 19, 1929, and that death occurred, on the date stated above, at 11:50 P m.

The CAUSE OF DEATH* was as follows:

Neoplasm of left ovary

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam + Laboratory

(Signed) A. F. Rice, M. D.

May 21, 1929 (Address) 24 E Mt Vernon

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Hebrew Cem

DATE OF BURIAL: 5/21 19 29

20 UNDERTAKER: Jack Levin

ADDRESS: 1439 E. Balto St

OF DEATH in plain terms, so that it may be properly classified. Every statement is important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 46138

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

7A-201 E 46138

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST. 10-14 WARD)

2-FULL NAME Louis Clements

(a) RESIDENCE NO. Preston & Valley ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Seventeen—

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Louis Clements

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Ellen Weaver

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address) Little Sisters of the Poor Preston & Valley

15 Filed MAY 21 1929, 19 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20th 1929

17 I HEREBY CERTIFY, That I attended deceased from May 9 , 1929 , to May 20 , 1929 , that I last saw h— alive on May 20 , 1929 , and that death occurred, on the date stated above, at 5 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) — yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Leonard Wood M. D.

May 21, 1929 (Address) 1216 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL May 22 1929

20 UNDERTAKER Rita Wiedefeld ADDRESS 914 Gilmor St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAY 21 1929

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46139 135 **E 46139**

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 24-34

CITY OF BALTIMORE: (No. South Balto. Gen'l. Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank E. Bauer

(a) RESIDENCE NO. 1735 Belt St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Bauer

6 DATE OF BIRTH (month, day, and year) June 5 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Frederick Md.
(State or country)

PARENTS

10 NAME OF FATHER John Bauer

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Catherine Fisher

13 BIRTHPLACE OF MOTHER (city or town) Frederick Md.
(State or country)

14 Informant Mrs. Faust

(Address) 1735 Belt St.

15 Filed ..., 19.. C. LAMSON JONES, M. D
Per ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1929.

17 I HEREBY CERTIFY, That I attended deceased from May 16, 1929, to May 19, 1929, that I last saw h[im] alive on May 19, 1929 and that death occurred, on the date stated above, at 4 30 P. m.

The CAUSE OF DEATH* was as follows:

Benign Prostatic Hypertrophy

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? At home

Did an operation precede death? Yes Date of May 14, 1929

Was there an autopsy? No

What test confirmed diagnosis? Pertalian Bottle

(Signed) E. A. Fleisher, M. D.

, 19 (Address) 1212 Belt St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery

DATE OF BURIAL 5/22 1929

20 UNDERTAKER J. Fenw McCully

ADDRESS 130 E. Fort.

OF DEATH in plain terms, so that it may be properly classified. Every question important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46140

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 46140

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Balto city Hosp ST. 11-W WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Fuller

(a) RESIDENCE NO. Carl Court Apt ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer 030

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant James Fuller
(Address) 99 N Fanvale St

15 Filed ... 19... HARRISON JONES, M. D. Registrar

AY 21 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/19/29

17 I HEREBY CERTIFY, That I attended deceased from 6/3, 1925, to 5/19, 1929, that I last saw h.im alive on 5/19, 1929 and that death occurred, on the date stated above, at 7:30 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis, Myocarditis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Lill. Langbein, M. D.

5/20 1929 (Address) Balto. city Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount	5 22 1929
20 UNDERTAKER J. W. Cook	ADDRESS 1217 E Fayette St

OF DEATH in plain terms, so that it may be properly classified. Make entries with ink. Be careful that all items are correct and complete. Answer each question. If none, or not applicable, write none, or insert a dash (—). Do not use ditto marks. Be particularly careful to make the answers to questions 16, 17, 19 and 20 full and complete, as they are important. See instructions on back of certificates.

Spgc.—2-29-28—L. F. S.—500 Blks.

Butler

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46141

CERTIFICATE OF DEATH

90

E 46141

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Balto City Hosp. ST. 5-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Martha Butler

(a) RESIDENCE NO. 1830 Mullins ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown.

6 DATE OF BIRTH (month, day, and year) Unknown 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown.

14 Informant John Butler
(Address) 1830 Mullins St

15 Filed MAY 2 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/16/29

17 I HEREBY CERTIFY, That I attended deceased from 7/14, 1927, to 5/16, 1929, that I last saw h.r alive on 5/16, 1929 and that death occurred, on the date stated above, at 3 30 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Bilateral ulcerations of legs

Myocarditis, Chronic

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Autopsy

(Signed) L. M. Champlain, M. D.

5/17, 1929 (Address) Balto City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Lebanon	May 21st 1929
20 UNDERTAKER Mrs. R. A. Elliott	ADDRESS 1320 Ashland Ave

IMPORTANT—Fill in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46142

HEALTH DEPARTMENT—CITY OF BALTIMORE

46

CERTIFICATE OF DEATH

E 46142

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 114 St. Dunstans Rd ST.) 27-46 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna F. Schmitt

(a) RESIDENCE NO. 114 St. Dunstans Rd ST. Homeland WARD
(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow.

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Edward D. Schmitt

6 DATE OF BIRTH (month, day, and year): Oct. 26, 1860

7 AGE — Years: 68 — Months: 6 — Days: 24 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Cuyahoga Falls Ohio.

PARENTS

10 NAME OF FATHER: Wm H. Bailey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ohio

12 MAIDEN NAME OF MOTHER: Noble

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ohio.

14 Informant: Dr. Franklin B. Anderson

(Address) 114 St. Dunstans Rd.

15 Filed May 21 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 20, 1929

17 I HEREBY CERTIFY, That I attended deceased from 9/29 1927 to 5/20 1929.

that I last saw h[er] alive on 5/20 1929

and that death occurred, on the date stated above, at 5.50 P m.

The CAUSE OF DEATH* was as follows:

Carcinomatosis.

(duration) 1 yrs. 8 mos. ds.

CONTRIBUTORY (Secondary): Epithelioma labia-uterus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of 9/20/27-

Was there an autopsy? yes 9/26/28.

What test confirmed diagnosis? Microscopic

(Signed) Edward Reinhardt M. D.

5/21 1929 (Address) Mt. Airy Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cuyahoga Falls Ohio

DATE OF BURIAL: May 21 1929

20 UNDERTAKER: Wm McKee & Sons

ADDRESS: Noble & Pa

MAY 21 1929

R.M.M.

IMPORTANT. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 46143

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 46143

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL (Ward) 5-8 WARD)

2-FULL NAME Bertha McKethan

(a) RESIDENCE No. 1202 Jefferson ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	black	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Barney

6 DATE OF BIRTH (month, day, and year) 4/21/97

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32		28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wool factory

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N.C.

PARENTS

10 NAME OF FATHER Calvin Henry

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Lottie Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C.

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed MAY 21 1929 C. HAMPSON JONES, M. D. Registrar

Per KMK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1929

17 I HEREBY CERTIFY, That I attended deceased from May 16 1929 to May 19 1929 that I last saw her alive on May 19 1929 and that death occurred, on the date stated above, at 5 40 p m.

The CAUSE OF DEATH* was as follows:

Cardio-renal disease, with aortic insufficiency, possible mitral lesion.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Alan Gregg, M. D.

19 (Address) JOHNS HOPKINS HOSPITAL

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary Cem.

DATE OF BURIAL 5-22 1929

20 UNDERTAKER Byron Knight 1218 McCulloh St

ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46144

CERTIFICATE OF DEATH

49

E 46144

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Balto city Hosp ST. 35 WARD)

2—FULL NAME Thos Buckley

(a) RESIDENCE NO. 808 E Pratt ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Christina Buckley

6 DATE OF BIRTH (month, day, and year) Oct. 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman 06

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm. Buckley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Ella Buckley

(Address) 2036 Clifton Ave

15 Filed 5-21-29 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/18/29

17 I HEREBY CERTIFY, That I attended deceased from 2/21/29, 19..., to 5/18, 19 29, that I last saw him alive on 5/18, 19 29 and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma Prostate & bladder

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. U. Lumpkin, M. D.

5/18, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Patricks Lawn	May 22 1929
20 UNDERTAKER	ADDRESS
Geo M. Zink & Son	811 N Wolfe

IMPORTANT. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 46145 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 46145

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3214 Kenyon Ave ST., 26-40 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Vedral

(a) RESIDENCE No. 3214 Kenyon Ave ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	baby

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 18-1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
			2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work ..... baby
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... Md
(State or country)

PARENTS

10 NAME OF FATHER Charles Vedral

11 BIRTHPLACE OF FATHER (city or town) ..... Md
(State or country)

12 MAIDEN NAME OF MOTHER Waggner

13 BIRTHPLACE OF MOTHER (city or town) ..... Md
(State or country)

14 Informant ..... Charles Vedral
(Address) 3214 Kenyon Ave

15 Filed ..... 19 .....
C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-20 1929

17 I HEREBY CERTIFY, That I attended deceased from 5/18 1929 to 5-20 1929, that I last saw her alive on 5/20 1929 and that death occurred, on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Patent foramen ovale

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Asphyxia Neonatum

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) Daniel Miller M. D.

5/21 1929 (Address) 1700 Edwy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cemetery — DATE OF BURIAL 5/21 1929

20 UNDERTAKER Wm Cook — ADDRESS 1217 8 Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAY 21 1929

Cor.—12-9-25—A Co.—200 Bks.

E 46146

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

182 E 46146

REGISTERED NO.

1-PLACE OF DEATH
City of BALTIMORE: (No. In Harbor in rear of Aliceanna and Chester Sts. St. 1-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME THOMAS J. CONLEY

(a) RESIDENCE NO. 634 S. Decker Ave. St. Ward
(Usual place of abode)
Length of residence in city or town where death occurred 12 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of - - -

6 DATE OF BIRTH (month, day, and year) February 12, 1912

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	17	3	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Foote Packing Co.

9 BIRTHPLACE (city or town)
(State or country) Virginia

PARENTS

10 NAME OF FATHER Fillmore Conley

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Florence Hammock

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

14 Informant Mr. Fillmore Conley (Father)
(Address) 634 S. Decker Ave

C. HAMPSON JONES, M. D.

MAY 21 1929 P.M. R. [illegible]

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 18, 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (inquest, autopsy or inquiry.) thereon and from the evidence obtained by said investigation (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

Sudden (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) fell from boat where he was working (duration) yrs. mos. d

(Signed) James H Taylor M. D.
(Coroner)

5 20 1929 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)
At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lodge, Northumberland Co. Va. Date of Burial: May 22, 1929

20 UNDERTAKER Henry Sander & Sons, Inc. ADDRESS BALTIMORE ST & BROADWAY

R.—WRITE PLAINLY, with pen and ink. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46147

38 E 46147

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. 8-16 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Streets

(a) RESIDENCE NO. 1117 N. Milton Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or mln.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Patrick McDermott

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Jane Carr

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Records of

(Address) Baltimore City Hospitals

15 Filed ..., 19 ... C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 14, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 14, 19 19, to May 14, 19 29, that I last saw her alive on May 14, 19 29, and that death occurred, on the date stated above, at 10:15 P m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis
Myocardial Insufficiency
Several months (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Syphilis (duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Phys + Lab analysis

(Signed) Warren McPherson, M. D.

, 19 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cemetery	May 28, 1929
20 UNDERTAKER	ADDRESS
George W. Zinkler	737 E. Eager

Information should be carefully supplied. Any blank will delay burial. Statement of OCCUPATION is very important. See instructions on back of certificates. Exact statement of OCCUPATION is required in plain terms, so that it may be properly classified.

Spec.—2-29-28—L. F. S.—500 Dks.

46148

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 V

E 46148

1—PLACE OF DEATH

BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE: (No. 4-25 ST.) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Nellie Braxton

(a) RESIDENCE NO. 135 arch ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced? (write the word)
Female	Col	wid

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Not given

6 DATE OF BIRTH (month, day, and year) December

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) out

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md

PARENTS

10 NAME OF FATHER Daniel Braxton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Nellie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Rentz

(Address) BALTIMORE CITY HOSPITALS

15 Filed MAY 21 1929, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-17-29

17

I HEREBY CERTIFY, That I attended deceased from 4-2, 19 29, to 5-17, 19 29, that I last saw her alive on 5-17 7:00 P, 19 29, and that death occurred, on the date stated above, at P. m.

The CAUSE OF DEATH* was as follows:

Acute Atelectasis left lung with pneumonia

(duration) yrs 1½ mos. ds.

CONTRIBUTORY (Secondary) Old pulmonary tuberculosis

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? X Ray

(Signed) [illegible], M. D.

, 19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cemetery	May 21 1929

20 UNDERTAKER John N Kerr

ADDRESS [illegible]

OF DEATH in plain terms, so that it may be properly classified. Last statement of occupation important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 46149 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 31 E 46149

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hospital ST. 18-16 (WARD)

2-FULL NAME Ruth Murray

(a) RESIDENCE No. 4 Arnold St ST. WARD Shady Side Md.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Colored	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Child

6 DATE OF BIRTH (month, day, and year) 1927.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Sarah Murry Hutton (Address) Churchton Md.

15 C. HAMPSON JONES, M. D. Registrar

Y 21 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 1927

17 I HEREBY CERTIFY, That I attended deceased from Apr 6 1929 to May 20 1927, that I last saw h(er) alive on May 20 1927, and that death occurred, on the date stated above, at 7.50 m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Tuberculosis

(duration)? yrs. mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Undetermined

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? X-ray

(Signed) B Harris M. D.

(Address) Provident Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Franklin Cem't Co.

DATE OF BURIAL May 24 1929

20 UNDERTAKER E H Baker

ADDRESS 27 Calvert

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46160 HEALTH DEPARTMENT—CITY OF BALTIMORE **E 46150**

CERTIFICATE OF DEATH

92

1—PLACE OF DEATH

REGISTERED NO. 11-25

CITY OF BALTIMORE: (No. 111 W. Monument ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Francis Dammann

(a) RESIDENCE NO. 111 W. Monument ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 83 yrs. 5 mos. 23 ds. How long in U. S., If foreign birth? - yrs. - mos. - ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Aileen Cowardin

6 DATE OF BIRTH (month, day, and year) Nov. 28, 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	5	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

10 NAME OF FATHER F. Wm. Dammann

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary McDonald

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant J. Francis Dammann Jr.
(Address) 140 S. Dearborn St. Chicago

15 Filed C. HAMPSON JONES, M. D.
Registrar

Y 21 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20th 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 1st, 1929, to May 20th, 1929, that I last saw h[illegible] alive on May 20th 1929 and that death occurred, on the date stated above, at 9 30 P. m.

The CAUSE OF DEATH* was as follows:

Thrombosis (Aortic)
Myocardial Degeneration

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Signs & Symptoms

(Signed) J. G. Chatard, M. D.

May 20th 1929 (Address) 1300 N. Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 5/22 1929

20 UNDERTAKER Henry U. Meads & Son

ADDRESS 805 N. Calvert

IF DEATH in plain terms, so that it may be properly classified. Causes must be important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 46151

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001

E 46151

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Church Home & Infirmary

City of BALTIMORE: (No. 126 N Broadway St. 1 Ward 8

2-FULL NAME Baby Boy Wood

(a) RESIDENCE NO. 6416 Pinehurst Rd. St._____ Ward_____

(Usual place of abode)

Length of residence in city or town where death occurred ____ yrs. ____ mos. ____ ds. How long in U. S., if of foreign birth? ____ yrs. ____ mos. ____ ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 20 / 29

7 AGE — Years | Months | Days | IF LESS than 1 day 2 hrs. or 53 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ____

(b) General nature of industry, business, or establishment in which employed (or employer) ____

(c) Name of employer ____

9 BIRTHPLACE (city or town) Baltimore Md.

(State or country)

PARENTS

10 NAME OF FATHER Edmund Scott Wood

11 BIRTHPLACE OF FATHER (city or town) ____

(State or country) Waterbury Conn.

12 MAIDEN NAME OF MOTHER Louise Houghton

13 BIRTHPLACE OF MOTHER (city or town) ____

(State or country) Baltimore

14 Informant ____

(Address) ____

15 Filed ____ C. HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1929

17

I HEREBY CERTIFY, That I attended deceased from May 20, 1929, to May 20, 1929, that I last saw him alive on May 20, 1929, and that death occurred, on the date stated above, at 9:13 a. m.

The CAUSE OF DEATH* was as follows:

Prematurely 6 1/2 mths

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) ____

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? ____

Did an operation precede death? ____ Date of ____

Was there an autopsy? ____

What test confirmed diagnosis? ____

(Signed) R. B. Peeler

, 19 (Address) Church Home & Infirm, M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL ____ Date of Burial ____

20 UNDERTAKER Church Home & Infirmary 19

ADDRESS ____

Commissioner of Health.

MAY 21 1929

Should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

211029

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46152

148 **E 46152**

REGISTERED NO.

(if death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Joseph Hospital St., 7-13 Ward)

2-FULL NAME Blanche M. Healy

(a) RESIDENCE NO. 1618 E. Chase St St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F.	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Herman W. B. Healy

6 DATE OF BIRTH (month, day, and year) Aug 5 May 22d. [redacted]/1908

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
20	9	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER James Kelley

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Ella Heisel

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto., Md.

14 Informant Herman W. B. Healy
(Address) 1618 E. Chase St.

15 Filed ....., 19 C. HAMPSON JONES, M. D. Registrar

MAY 21 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

(Post Partun) Puerpal eclampsia

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Nephritis.

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature], M. D.

5/21/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL May 22 1929

20 UNDERTAKER John Ulrich

ADDRESS 2008 Orleans

CON. BE—WRITE PLAINLY, WITH UNFADING INK. tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46153

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 46153

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 202 N. Streeper ST. 6-11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Fuchs

(a) RESIDENCE NO. 202 N. Streeper ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of: late John Fuchs

6 DATE OF BIRTH (month, day, and year): Dec 23/67

7 AGE — Years: 61 Months: 4 Days: 26 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Henry Morgereth

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ger.

12 MAIDEN NAME OF MOTHER: Anna Flottermesch

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ger

14 Informant: Jos. H. Fuchs

(Address): 202 N. Streeper St

15 Filed MAY 21 1929 C. HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 18/29

17 I HEREBY CERTIFY, That I attended deceased from May 15 1929, to May 18 1929, that I last saw her alive on May 17, 1929 and that death occurred, on the date stated above, at 6 5 37 P. m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

not definitely stated yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) Benj. S. Hayden, M. D.

5/17/1929 (Address) 1216 N. Carolina St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: 5/22 1929

20 UNDERTAKER: Philip Herring — ADDRESS: 2016 Orleans St

IMPORTANT. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46154

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46154

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4004 Hickory Ave ST., 13 WARD)

2—FULL NAME Alice M. Morfoot

(a) RESIDENCE NO. 4004 Hickory Ave ST., 13 WARD
(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. 6 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William F. Morfoot

6 DATE OF BIRTH (month, day, and year) July 14 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	10	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Joseph F. Tyson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Jennie Ranck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs Raymond Mahenheimer

(Address) Girard, Ohio

15 Filed MAY 21 1929, 19 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20-1929

17 I HEREBY CERTIFY, That I attended deceased from Mar 15, 1929, to May 20, 1929, that I last saw her alive on May 19th, 1929 and that death occurred, on the date stated above, at 1.25 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Gout (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardio Vascular disease (duration) years yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Chas. H. Didusbury M. D.

May 21, 1929 (Address) 850 W. 36th

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL May 22 1929

20 UNDERTAKER Horace F. Burgee — ADDRESS 31 Falls Road.

OF DEATH in plain terms, as exact as the physician's, important. See instructions on back of certificates.

MAY 21 1929

Spec. 2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46155

CERTIFICATE OF DEATH

90 E 46155

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 810 N. Pat. Pk. Ave ST., 9-12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary E. Dodson

(a) RESIDENCE NO. 810 N. Pat. Pk. Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced (or) WIFE of: Andrew J. Dodson

6 DATE OF BIRTH (month, day, and year): Jan 7/63

7 AGE — Years: 66 Months: 4 Days: 14 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Linsey Flemons

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Sarah E. Bromley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

11 Informant: Andrew J. Dodson

(Address) 810 N. Pat. Pk. Ave

15 Filed ..... 19 ..... Registrar.

C. HAMPSON JONES, M. D.

Y 21 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 21/29

17 I HEREBY CERTIFY, That I attended deceased from April 12, 1929, to May 21, 1929, that I last saw h[illegible] alive on May 20-29, 19..., and that death occurred, on the date stated above, at 6 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Duration (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Florence A. Owen, M. D.

19 (Address) 2127 Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side foe additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Egan's Wharf Va

DATE OF BURIAL: 5/22 1929

20 UNDERTAKER: Philip Herwig

ADDRESS 2016 Eutaw St

OF DEATH in plain terms, so that it may be properly classified. important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46156 E 46156

CERTIFICATE OF DEATH.

117

1-PLACE OF DEATH

City of BALTIMORE: (No. Church Home + Hosp. 16-37 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Tillie Sas

(a) RESIDENCE NO. 3417 Mt. Pleasant Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb 15 1906

7 AGE: Years 23 Months 3 Days 3 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Adam Wasiewski

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Poland

12 MAIDEN NAME OF MOTHER Stanistawa Bronska

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Poland

14 Informant John Sas

(Address) 3417 Mt. Pleasant St.

Y 21 1929 C. HAMPSON JONES, M. D. Registrar

By ACH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/21/ 1929

17 I HEREBY CERTIFY, That I attended deceased from April 8, 1929, to May 21, 1929, that I last saw h.. alive on May 21, 1929, and that death occurred, on the date stated above, at 7.40 A. m.

The CAUSE OF DEATH* was as follows:

Ulcerative perforation of Colon

Pericecal abscess

General peritonit.

(duration) .....yrs. 1 mos. 11 ds.

CONTRIBUTORY (Secondary) Bronchio Pneumonia

(duration) .....yrs. .....mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 5/11/29

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) John Mace Jr, M. D.

, 19 (Address) Church Home Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Date of Burial: May 24 1929

20 UNDERTAKER: John M Weber ADDRESS: 401 A Chester Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46157

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

10-103

E 46157

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 13 S Carey ST., 18-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lena G. Weber

(a) RESIDENCE NO. 13 S Carey ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 12 1917

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	11	9	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Raymond Weber

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Blanche Hayden

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mr Raymond Weber

(Address) 13 S Carey st

15 DATE RECEIVED Y 21 1929

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/21/29

17 I HEREBY CERTIFY, That I attended deceased from 5/19/29, 19..., to 5/21/29, 19..., that I last saw her alive on 5/21/29, 19..., and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Meningitis

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Diphtheria

(duration) yrs. mos 15 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Stafford Dow M. D.

, 19 (Address) 1 W Mt Royal Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem

DATE OF BURIAL 5/22/29

20 UNDERTAKER Geo A Foley Sons

ADDRESS Fulton & Fayette

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46158 37-02 **E 46158**

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hosp. St. 15-22 Ward)

2-FULL NAME Isaac Carter

(a) RESIDENCE NO. 1355 N. Stricker St., Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Col

5 Single, Married, Widowed or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: No.

6 DATE OF BIRTH (month, day, and year): June 4-1928

7 AGE: Years: 1 Months: 4 Days: 14 IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: none.
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9 BIRTHPLACE (city or town): Baltimore
(State or country): .....

PARENTS

10 NAME OF FATHER: Lee Webby

11 BIRTHPLACE OF FATHER (city or town): Va.
(State or country): .....

12 MAIDEN NAME OF MOTHER: Fannie Carter

13 BIRTHPLACE OF MOTHER (city or town): Va.
(State or country): .....

14 Informant: Fannie Carter
(Address): 1355 Stricker

Filed MAY 21 1929

19 HAMPSON JONES, M. D. Registrar

By .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): May 18th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Autopsy & Inquiry (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

General Tuberculosis

(duration) ... yrs. 2 mos. ... ds.

CONTRIBUTORY (Secondary) .....

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? No.

Did an operation precede death? No. Date of .....

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) Fred. Fink, M. D. Coroner

(Address) May 19th 1929

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: 5/22/1929

20 UNDERTAKER: Mrs Geo. H. Holland — ADDRESS: 160 Druid Hill

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 46189

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 46189

38

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No. 111 Belmont ST. 8-13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Antonino

(a) RESIDENCE NO. 1105 N Caroline ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M.

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) October 8. 1881.

7 AGE Years 47. Months 5. Days 11 If LESS than 1 day, hrs or min. 5 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER John Antonino

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Filomina Russello

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant C. Barrabelli

(Address) 1105 N. Caroline St

15 Date 6-11-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1929

17 I HEREBY CERTIFY, That I attended deceased from May 12. 1929. to May 19. 1929. that I last saw him alive on May 19. 1929. and that death occurred, on the date stated above, at 6.30 p. m.

The CAUSE OF DEATH* was as follows:

Syphilis of Central Nervous System.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinic & Lab

(Signed) Herman Chor M. D.

6-11-1929 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL May 22 1929.

20 UNDERTAKER Wendell & Klippel

ADDRESS 504 S Eden

AGE should be stated EXACTLY. PHYSICIANS should see that it may be properly classified. Exact statement of OCCUPATIONS on back of certificates.

CAUSE OF DEATH in plain terms, so that

TION is very important See instructions

mation should be carefully supplied. Ac-

211929

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46160

CERTIFICATE OF DEATH

57

E 46160
REGISTERED NO.

1-PLACE OF DEATH

City of Baltimore: (No. 1602 Lancaster St. 7-4 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Carrie Schultz

(a) RESIDENCE NO. 1602 Lancaster St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
female	white	widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Frank Schultz

6 DATE OF BIRTH (month, day, and year) May 13 1875

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or .... min.
	54		7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Home work
(b) General nature of industry, business, or establishment in which employed (or employer) at home
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Poland

PARENTS

10 NAME OF FATHER Casmir Drozd

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland

14 Informant Edward Matthews
(Address) 1631 E 33rd st.

Filed MAY 22 1929 HAMPSON JONES, M. D., Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? 1602 Lancaster

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) James M Hanlon, M. D.

5/21. 1929 (Address) 709 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	May 23 1929
20 UNDERTAKER	ADDRESS
George A Weber	705 E Chase st

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

Smolinski

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46161

CERTIFICATE OF DEATH

E 46161

1—PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. University Hospital ST. ..... WARD)

2—FULL NAME Eugene Smolinski.

(a) RESIDENCE NO. 730 S. Ann ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? 26 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White.	married,

a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Julia Smolinski.

6 DATE OF BIRTH (month, day, and year) Aug. 25 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	45	8	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer) Longshoreman

(c) Name of employer Patapsco Ship Co.

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER John Smolinski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant Julia Smolinski.

(Address) 730 S. Ann St.

15 Filed MAY 24 1929, 19 Per ..... Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-21-'29.

17 I HEREBY CERTIFY, That I attended deceased from 5/20/29, 1929, to 5/21/, 1929, that I last saw him alive on alive 5/21/29 1929 and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Marked Arteriosclerosis

Coronary Thrombosis

Immediate (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? no Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) C. F. Smithwick, M. D.

, 19 (Address) University Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cem	May 24 1929
20 UNDERTAKER	ADDRESS
George A. Weber	705 S. Ann St.

IMPORTANT—In particulars, so that they may be properly classified. Please answer all questions. Be sure to fill in all blanks. Be very careful to see that every statement is correct and complete. Do not leave any blanks

Spec.—1-10-21—M&T—1500 Bks.

223734

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46162

E 46162

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL (Street) (Ward) 16-13

2-FULL NAME Martha Jean (or Mrs) Brown

(a) RESIDENCE NO. 625 N. Spring ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec. 15-1914

7 AGE: Years 15 Months 5 Days 5 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Pa.

PARENTS

10 NAME OF FATHER: Charles Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Henrietta Burke

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Friends

(Address) JOHNS HOPKINS HOSPITAL

Filed MAY 22 1929 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 20 1929

17

I HEREBY CERTIFY, That I attended deceased from Mar 25. 1929. to May 20. 1929.

that I last saw her alive on May 20. 1929.

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Sub acute bacterial endocarditis

Strept - Viridans

(duration) 2 yrs. 4 mos 0 ds.

CONTRIBUTORY (Secondary): Myocardial disease

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Blood Culture

(Signed) C. H. Jones, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Chamberlain Pa. DATE OF BURIAL: May 23 1929

20 UNDERTAKER: Chas. H. Johnston ADDRESS: 416 N. Gilmor St.

mation should be carefully supplied. AGE should be stated EXACTLY. If CHILDREN, should the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—I-10-21—M&T—1500 Bks.

Harper

E 46163 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 S.

REGISTERED NO. E 46163

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2025 N. Bentalou ST., 15-6X WARD)

2-FULL NAME Mrs. Rose Harper

(a) RESIDENCE No. 2025 N. Bentalou ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Harper

6 DATE OF BIRTH (month, day, and year) Sept 15 66

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or ... min.
	62	8	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home work

(b) General nature of industry, business, or establishment in which employed (or employer) at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER F Hohnstein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Plitt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Frank Harper

(Address) 2025 N Bentalou

Filed MAY 22 1929 19 C. HAMPSON JONES, M. D. Registrar

Ref. KMC

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19 1929

17 I HEREBY CERTIFY, That I attended deceased from May 7, 1929, to May 19, 1929, that I last saw her alive on May 18, 1929, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Uraemic Convulsions

(duration) four minutes

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) 5 to 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Usual

(Signed) J. Abbott Ewell M. D.

May 21, 1929 (Address) 2940 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL May 22 1929

20 UNDERTAKER W M Routzon

ADDRESS 2238 N Mt

mation should be carefully supplied. AGE should be stated EXACTLY. ILLEGIBLE or UNINTELLIGIBLE wording in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

90

E 46164

CERTIFICATE OF DEATH

E 46164

1—PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO.

CITY OF BALTIMORE: (No. 8-17 ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Dennis Schultz

(a) RESIDENCE NO. 1826 N. Duncan ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Unknown

PARENTS

10 NAME OF FATHER Dennis McCartney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ruth Roff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Records of

(Address) Balto. City Hospitals

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1929, to May 19, 1929, that I last saw her alive on May 19, 1929 and that death occurred, on the date stated above, at 7:45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis Senility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Emphysema, Arteriosclerosis Hypertension

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no What test confirmed diagnosis? Physical Exam

(Signed) Harry [illegible], M. D.

, 19 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	5 23 1929
20 UNDERTAKER W. M. Cook	ADDRESS 127 N. Paca St.

OF DEATH in plain terms, so that it may be properly classified. Each statement of fact is important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 46165 HEALTH DEPARTMENT—CITY OF BALTIMORE E 46165

CERTIFICATE OF DEATH.

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West Balto Genl Hosp ST. 15-66 WARD)

2-FULL NAME Norman Matthews

(a) RESIDENCE NO. 2127 Ridgehill Ave ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jane Matthews

6 DATE OF BIRTH (month, day, and year): Nov 18 1853

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
75	6	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Painter Retired

(b) General nature of industry, business, or establishment in which employed (or employer): 05

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: James Matthews

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore

12 MAIDEN NAME OF MOTHER: Jenkinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14

Informant: James Matthews

(Address) 2127 Ridgehill Ave

15

Filed ..... 19 ..... HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/20/29 19

17

I HEREBY CERTIFY, That I attended deceased from 5/16/29, 19 ....., to 5/20/29, 19 ....., that I last saw him alive on 5/20/29, 19 ....., and that death occurred, on the date stated above, at 1 30 P m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

Chronic myocarditis

Prostatic Hypertrophy benign

Arteriosclerosis (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical, Laboratory, Autopsy findings

(Signed) Benjamin Lemmon M. D.

, 19 (Address) West Balto Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park

DATE OF BURIAL: 5 23 19 29

20 UNDERTAKER: H. C. Cook

ADDRESS: 274 Fulton

MAY 22 1929

Spec.—2-29-28—L. F. S.—500 Bks.

E 46166 HEALTH DEPARTMENT—CITY OF BALTIMORE 74-001 **E 46166**

CERTIFICATE OF DEATH

REGISTERED NO. 8-819

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1313 N. Broadway ST., 8th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emma Jackson

(a) RESIDENCE NO. 1313 N. Broadway ST., 8th WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm H Jackson

6 DATE OF BIRTH (month, day, and year) Mar. 1—1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
♀	63	2	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework (Own)

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Wm H. Mothsagel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Fleurer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Wm H Jackson

(Address) 1312 N. Broadway

15 Filed MAY 22 1929, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20 - 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1929, to May 20, 1929, that I last saw her alive on May 20, 1929 and that death occurred, on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Arterio - Sclerosis (5 months)
Cerebral Hemorrhage (10 days)
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Congestion
(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Opthalmoscopic Test

(Signed) J M Dellett, M. D.

May 21, 1929 (Address) 621 Cathedral Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	5/23 1929
20 UNDERTAKER Jos Cook	ADDRESS 1217 St Paul St

OF DEATH in part items, as they are important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Ms 5-622 6836

E 46167

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49

E 46167

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital ST. 8-16 WARD)

2-FULL NAME Christian Sr. Schlerf

(a) RESIDENCE NO. 1607 N. Patterson Pk Ave ST. ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Amanda Schlerf

6 DATE OF BIRTH (month, day, and year): Jan 10, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	65	4	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Baker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Ace Baking Co

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Amanda Schlerf

(Address) 1607 N. Patterson Pk Ave

Filed 5-20 1929 C. HAMPSON JONES, M. D. Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 20 1929

17 I HEREBY CERTIFY, That I attended deceased from April 20, 1929, to May 20, 1929, that I last saw him alive on May 20, 1929, and that death occurred, on the date stated above, at 7:15 P m.

The CAUSE OF DEATH* was as follows:

Empiegallo.
Syringo-myelia (?)
Cardiac failure.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Frederick S. Wolf, M. D.

5-20 1929 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore

DATE OF BURIAL: 5 24 1929

20 UNDERTAKER: H. Cook

ADDRESS: 1214 Eutaw

AY 221929

mation should be carefully supplied. AGE should be stated EXACTLY. If unknown, about how CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 46168 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 46168 (1-001)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2301 Maisel ST., 25-32 WARD)

2-FULL NAME James Lionel Fountain

(a) RESIDENCE No. 2301 Maisel ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ___ yrs. 6 mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillian Fountain

6 DATE OF BIRTH (month, day, and year) Nov 22 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	49	6	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Musician

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Samuel Fountain

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary E Robertson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) D C

14 Informant Lyglia Parmer (Signature) (Address) St James Depot

15 Filed MAY 22 1929 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21 1929

17 I HEREBY CERTIFY, That I attended deceased from April 14, 1929, to May 21, 1929, that I last saw h— alive on May 21, 1929, and that death occurred, on the date stated above, at 1:30 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. 1 mos 7 ds.

CONTRIBUTORY (Secondary) General paralysis

(duration) 1 yrs. — mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms and signs.

(Signed) Raymond V Hamm, M. D.

May 22, 1929 (Address) Parkland.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL May 22 1929

20 UNDERTAKER Jos Block

ADDRESS 1005 West Baltimore St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

22-E 46169

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46169

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 9-47 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Bramzell

(a) RESIDENCE NO. 805 Vendble Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George L. Bramzell.

6 DATE OF BIRTH (month, day and year): June 26 1898

7 AGE — Years: 30 — Months: 11 — Days: 6 — If LESS than 1 day, hrs. or min.: 8.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: H. W. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Geo. Bunkley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Marginal-Poppett

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Records JOHNS HOPKINS HOSPITAL

15. Filed 5/23 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 22 1929

17

I HEREBY CERTIFY, That I attended deceased from May 20 1929 to May 22 1929, that I last saw h[illegible] alive on May 22 1929, and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Scarlet Fever

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 2

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Clinical Observation

(Signed) Sidney G. Gladstone, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkewood — DATE OF BURIAL: 5/23 1929

20 UNDERTAKER: W. C. Black — ADDRESS: 927½ Broadway

mation should be carefully supplied. Also, answer all questions. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 46170 HEALTH DEPARTMENT—CITY OF BALTIMORE E 46170

CERTIFICATE OF DEATH.

92

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) U.S. Marine Hospital, Balto, Md. (STREET) 93-33 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas A. Neveker

(a) RESIDENCE NO. 32 E. Hamburg St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) August 1, 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	9	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pantryman

(b) General nature of industry, business, or establishment in which employed (or employer) Seaman

(c) Name of employer S.S. "Allegheny"

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George Neveker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary E. ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Records, U.S. Marine Hospital Baltimore, Md.

15 Filed 19 C. HARRISON JONES, M. D. Registrar

MAY 22 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21 19 29

17

I HEREBY CERTIFY, That I attended deceased from April 5, 19 29, to May 21, 19 29,

that I last saw him alive on May 21, 19 29,

and that death occurred, on the date stated above, at 2:30 A.m.

The CAUSE OF DEATH* was as follows:

Hemiplegia, left side, cause thrombosis of right middle cerebral artery

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Degeneration of the Central nervous system (duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? Baltimore

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Houston G. Foster M. D.

5/21 19 29 (Address) U.S. Marine Hospital, Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — DATE OF BURIAL May 24 1929

20 UNDERTAKER Margaret G. Flynn — ADDRESS 1422 Light

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 46171

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

188-103

E 46171

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Paul & Fayette Sts. Ward 4-7)

2-FULL NAME John W. Hagert.

(a) RESIDENCE NO. Summit Ave. Raspeburg Balto Co. Md. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, HUSBAND of (or WIFE of) Anna Hagert.

6 DATE OF BIRTH (month, day, and year) December 7 1863

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	65	5	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Teamster.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Frank J. Hagert.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany.

12 MAIDEN NAME OF MOTHER Anna Troutwein.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany.

14 Informant George W. Hagert. (son)
(Address) 16 N. Hare St.

15 Filed MAY 22 1929 C. HAMPSON JONES, M. D., Registrar
BY Roth

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Internal Injuries. Run over and crushed about the body by having been run over by a bus. Accidental Death.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? St. Paul & Fayette Sts

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto Reinhardt, M. D.

5/21. 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn

DATE OF BURIAL May 22 1929

20 UNDERTAKER John Ullrich

ADDRESS 2008 Orleans

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—1. F. S.—500 Bks.

E 46172 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 46172

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Baltimore City Hospitals ST., 5-8 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mamie Johnson

(a) RESIDENCE NO. 1118 Orleans st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. 21 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER Rody Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Carolina Porter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant Hospital Records (Address)

15 Filed C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20, 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec. 15, 19 27, to May 20, 19 29, that I last saw her alive on May 20, 19 29 and that death occurred, on the date stated above, at 2.10 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculous Tuberculosis

(duration) [illegible] yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No Clinical Diagnosis

What test confirmed diagnosis

(Signed) Henry Smith, M. D.

5-20, 19 29 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Edgewood Cemetery	May 22 1929
20 UNDERTAKER	ADDRESS
Mrs. Joseph G. Cook	1302 Pennsylvania Ave.

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46173

CERTIFICATE OF DEATH.

E 46173

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 762 West Mulberry St., 17-7th WARD)

2-FULL NAME Mason Johnson —

(a) RESIDENCE NO. 762 West Mulberry — ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	Colored	widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 4th 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	30	2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer National Basket Co

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Mason Johnson —

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Virgin Carroll

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Oscar Johnson Brother

(Address) 915 Carlington

MAY 22 1929 FILED HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21— 1929

17 I HEREBY CERTIFY, That I attended deceased from March 21— 1929, to May 21— 1929

that I last saw him alive on May 20 1929

and that death occurred, on the date stated above, at 6 — a. m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Samuel A Cain M. D.

, 19 (Address) 937 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL 5-24 1929

UNDERTAKER Charles G Cooper

ADDRESS 3147 Eastern Ave

mation should be carefully supplied. Any omission may be properly classified. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 46174

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46174

CERTIFICATE OF DEATH

202

1-PLACE OF DEATH

City of Baltimore: (No.) Mercy Hospital. St. 21-29 Ward

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel Joseph Fetzer.

(a) RESIDENCE NO. 221 Scott St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. 4 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) January 8, 1894

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	35	4	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Boiler maker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Hayward Bartlett Co.

9 BIRTHPLACE (city or town)
(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Joseph Fetzer.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Martinsburg W. Va.

12 MAIDEN NAME OF MOTHER Alice Tyler.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore, Md.

14 Informant Alice C. Fetzer. (mother)
(Address) 221 Scott St.

15 Filed ..., 192.. C. HAMPSON JONES, M. D.
Registrar

MAY 22 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20, 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Internal Hemorrhage. Punctured wound of the abdomen. Accidentally struck in the abdomen by a piece of flying metal. Embolism. (duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary) (duration) ..yrs. 8 mos. ..ds.

18 Where was disease contracted if not at place of death? Scott & Pratt

Did an operation precede death? Yes. Date of May 17, 1929

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Holl Heinhardt. M. D.

5/22. 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem.	May 23 19 29
20 UNDERTAKER Jos Goerdens & Son	ADDRESS 2178 Eu

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 46175 HEALTH DEPARTMENT—CITY OF BALTIMORE E 46175

CERTIFICATE OF DEATH. 100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 601 S. Rappolla ST., 26 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Betty Lee Voight

(a) RESIDENCE No. 601 S. Rappolla St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 9 mos. ds. How long in U. S., If of foreign birth? yrs. 10 mos. 5 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 16 - 1928

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		10	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Oscar Earl Voight

11 BIRTHPLACE OF FATHER (city or town) W. Va (State or country)

12 MAIDEN NAME OF MOTHER Altha Jane Smith

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant Oscar Earl Voight

(Address) 601 S. Rappolla.

15 Filed MAY 22 1928 C. HAMPSON JONES, M. D. Registrar

Per L. E. Helms

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21 1929

I HEREBY CERTIFY, That I attended deceased from May 15th, 1929, to May 21, 1929, that I last saw h[illegible] alive on May 21 1929 and that death occurred, on the date stated above, at 4 Hr 7 m.

The CAUSE OF DEATH* was as follows:

Acute Bronchopneumonia

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Thomas A. Schmidinger, M. D.

, 19 (Address) 451 E Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery DATE OF BURIAL May 23rd 1929

20 UNDERTAKER Riley & Sisco Inc. ADDRESS 1533 Hoye St

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 46176

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46176

CERTIFICATE OF DEATH

3-5 188-103

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of Baltimore: (No. Mercy Hospital St., Ward)

2-FULL NAME Felomeno Cotone.

(a) RESIDENCE NO. 210 Slemmer Alley. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. ds. How long in U. S., if of foreign birth 46 yrs. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Do not know.

6 DATE OF BIRTH (month, day, and year): Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	76	------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town):
(State or country): Italy.

PARENTS

10 NAME OF FATHER: Geochina Cotone.

11 BIRTHPLACE OF FATHER (city or town):
(State or country): Italy.

12 MAIDEN NAME OF MOTHER: Carlina ------

13 BIRTHPLACE OF MOTHER (city or town):
(State or country): Italy.

14 Informant: Philip Cotone., (nephew)
(Address) Cumberland, Misc.

15 Filed ....., 19.... C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 19, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured ribs and femur. Walked into side of auto truck. Accidental.

Arterio sclerosis, Chronic Interstitial Nephritis. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Thrombosis.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? in front of 886 E. Pratt

Did an operation precede death? Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Steinhardt, M. D.

5/21, 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	May 22 1929
20 UNDERTAKER: Frank V Pipitone	ADDRESS 2818 E. Balto St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46177

CERTIFICATE OF DEATH

91-02 E 46177

1-PLACE OF DEATH

City of Baltimore: (No. Sinai Hospital St. 5-8 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis Pavis

(a) RESIDENCE NO. 110 Aisquith St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, with pen and ink. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Rose Pavis

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	70			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Russia

PARENTS

10 NAME OF FATHER Abraham Pavis

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Lipsie Overbook

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Rose Pavis
(Address) 110 Aisquith St

15 Filed ..... 19.. C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, Autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) General arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible], M. D.

5/22/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rosedale Cem	5/22 1929
20 UNDERTAKER Sol Levinson & Bro	ADDRESS 1127 E Balto St

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46178 E 46178

CERTIFICATE OF DEATH.

91-002

REGISTERED NO. 9332

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 203 (Street) Dickman ST (Ward) 23

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Julia A. Nelson

(a) RESIDENCE NO. 203 Dickman ST 23 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Nelson

6 DATE OF BIRTH (month, day, and year) May 10 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69		11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Tenn

PARENTS.

10 NAME OF FATHER John Keys

11 BIRTHPLACE OF FATHER (city or town) (State or country) Tenn

12 MAIDEN NAME OF MOTHER Workman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Tenn

14 Informant Thos Nelson

(Address) 203 Dickman St

15 Filed MAY 22 1929, 19 E. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21 1929

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1929, to May 21, 1929

that I last saw h alive on May 21, 1929

and that death occurred, on the date stated above, at 3-30 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Indefinite

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. K. Campbell M. D.

5/22/1929 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Jonesboro, Tenn. DATE OF BURIAL 5/24 1929

20 UNDERTAKER S. Frew McCully ADDRESS 130 E Fort

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46179 ~~22~~4924 12 40 P.m

CERTIFICATE OF DEATH.

X 135 E 46179

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. 7-4 WARD)

2-FULL NAME Noah Belcher

(a) RESIDENCE NO. Bud, W. Va ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rebeca Belcher

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE: Years 69; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) W Va

PARENTS

10 NAME OF FATHER Unk

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Polly Mahn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Records

14 Informant (Address) JOHNS HOPKINS HOSPITAL

15 [illegible] 19 C. HAMILTON JONES, M. D. Registrar

MAY 22 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21 19 29

17 I HEREBY CERTIFY, That I attended deceased from May 1 .19 29. to May 21 .19 29

that I last saw him alive on May 21 .19 29

and that death occurred, on the date stated above, at 1 p m.

The CAUSE OF DEATH* was as follows:

Streptococcus - bilateral

10 days

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Benign Prostatic hypertrophy

(duration) yrs. mos. days

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 5/7/29

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) [illegible] M. D.

.19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bud West Va — DATE OF BURIAL: 5/22/29

20 UNDERTAKER: Joseph Ahrens — ADDRESS: 224 Bway

mation should be carefully supplied. Any omission or error should be corrected. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—2-29-28—L. F. S.—500 Blks.

E 46180

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46180

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2422 Annapolis Ave ST., Mt Winans WARD 25-32)

REGISTERED NO. 161-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Boy Jackson

(a) RESIDENCE NO. 2422 (Usual place of abode) Annapolis Ave ST., Mt Winans WARD

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) May 14, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	0	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓ old

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Arthur Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elsa Hutchinson

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant mother

(Address) 2422 Annapolis Ave JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... C. HAMILTON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 14, 1929, to May 21, 1929, that I last saw h.i.m alive on May 20, 1929 and that death occurred, on the date stated above, at 6.30 A m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. Alexander Lowy, M. D.

, 19 (Address) 1516 Madison Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	19 MAY 22 1929

20 UNDERTAKER

ADDRESS

C. Hamilton Jones Commissioner of Health

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46181

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

161-00

E 46181

1—PLACE OF DEATH

REGISTERED NO. 25-52

CITY OF BALTIMORE: (No. 2419 Huron St Mt Winans ST., 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Meredith Jackson Bowie

(a) RESIDENCE NO. 2419 Huron St Mt Winans ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) May 20, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or 30 min.
	0	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓ none

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Meredith Jackson

11 BIRTHPLACE OF FATHER (city or town) unknown
(State or country)

12 MAIDEN NAME OF MOTHER Blanche Bowie

13 BIRTHPLACE OF MOTHER (city or town) Annapolis
(State or country) Maryland

14 Informant mother
(Address) 2419 Huron St Mt Winans

15 Filed MAY 22 1929, 19 G. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1929, to May 20, 1929

that I last saw h.i.m. alive on May 20, 1929

and that death occurred, on the date stated above, at 7.00 P m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. Alexander Mosely, M. D.

, 19 (Address) 1516 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	19 MAY 23 1929

20 UNDERTAKER Commissioner Health.

ADDRESS

Par. No. 3500 ORD

Par. Wm. A. WOOLLEY

important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 46182

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46182

CERTIFICATE OF DEATH

161-001

1-PLACE OF DEATH Mercy Hospital

City of BALTIMORE: (No. Calvert & Saratoga Sts. 25-75 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Betty Lois Spanoil

(a) RESIDENCE NO. 907 Washburn ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 18/1929.

7 AGE Years 1 Months Days IF LESS than 1 day 5 hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Mercy Hospital

(State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Louis C Spanoil

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Ohio.

12 MAIDEN NAME OF MOTHER Rebecca Recker

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Mother

(Address)

15 Filed MAY 22 1929 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 19/29. 19

17 I HEREBY CERTIFY, That I attended deceased from May 18, 19 29, to May 19, 19 29,

that I last saw h er alive on May 19, 19 29,

and that death occurred, on the date stated above, at 2 40 A M.

The CAUSE OF DEATH* was as follows:

asphyxia.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Premature birth - 7th month.

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Phy Examination

(Signed) Frank Fuller Morris M. D.

19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

Date of Burial 19

20 UNDERTAKER

ADDRESS

MAY 1929

N.B.—WRITE PLAINLY, with pen and ink. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 46183

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

188-103

E 46183

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. City Hospital St., 19-N Ward)

2-FULL NAME Geo H Bowman

(a) RESIDENCE NO. 316 Calhoun St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Hannah.

6 DATE OF BIRTH (month, day, and year) Dec 9-1864

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	65	5	11	12

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Mariner
(b) General nature of industry, business, or establishment in which employed (or employer) Sea
(c) Name of employer American Tin Co

9 BIRTHPLACE (city or town)
(State or country) Maryland

PARENTS

10 NAME OF FATHER Geo. W. Bowman

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary C. Wray

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant
(Address) 2614 N. Fremont Ave

15 Filed 19 C. HAMPSON JONES, M. D. Registrar
Per

Y 221929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:
Auto Acc
Fracture of thigh

(duration) yrs. 2 mos. ds.
CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Calhoun St Residence

Did an operation precede death? — Date of —
Was there an autopsy? No
What was confirmed diagnosis? Hypostatic Pneumonia

(Signed) G C Glades M. D.
19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL 5/24 1929

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46184

CERTIFICATE OF DEATH

× 177

E 46184

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Balto City Hospital St. 16-37 Ward)

2-FULL NAME Mary Everts

(a) RESIDENCE NO. North Pt Rd & Eastern St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of James Everts

6 DATE OF BIRTH (month, day, and year) Jan 11 1887

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	40	4	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Home work
(b) General nature of industry, business, or establishment in which employed (or employer) At home
(c) Name of employer

9 BIRTHPLACE (city or town) Balto City
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant James Everts
(Address) North Pt Rd & Eastern Ave

15 Filed MAY 22 1929 C. HAMPSON JONES, M. D. Registrar
per AHH

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Investigation
(Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.
The CAUSE OF DEATH* was as follows:
Swelling of Left Hydro-chloric acid — Unable to Urinate for nearly two weeks
Accident (duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? North Pt Rd Eastern Ave
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) James M Fenlon, M. D.
May 22 1929 (Address) 702 Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross German Hill	May 24 1929
20 UNDERTAKER	ADDRESS
John M Weber	701 S Chester St

MAY 22 1929

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 46185

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46185

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST. 42-30 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Miller or Leimberger

(a) RESIDENCE NO. 619 W. Conway st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice Miller

6 DATE OF BIRTH (month, day, and year) 1908

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Jessie Leimberger

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Delia Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Hospital Records

(Address)

15 Filed MAY 22 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 19 29, 19, to May 21, 19 29,

that I last saw him alive on May 21, 1929

and that death occurred, on the date stated above, at 5.30 a. m.

The CAUSE OF DEATH* was as follows:

Caseous pneumonia

(duration) 1 mo. 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Clinical & autopsy

(Signed) Henry C. Smith, M. D.

5-21-, 19 29 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Calvary Cem	May 25 1929
20 UNDERTAKER	ADDRESS
Robert J. Williams	1515 N. Eden st

important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46186

CERTIFICATE OF DEATH.

29

E 46186

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 509 Walton St. 17-24 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm J. Allen

(a) RESIDENCE NO. 509 Walton St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed or divorced, HUSBAND of (or) WIFE of: Estella Allen

6 DATE OF BIRTH (month, day, and year): Oct - 25 - 1864

7 AGE: Years 64 | Months 6 | Days 26 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Common Labor

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer: 0

9 BIRTHPLACE (city or town) .....

(State or country): Va.

PARENTS

10 NAME OF FATHER: Benj. Allen

11 BIRTHPLACE OF FATHER (city or town) .....

(State or country): Va.

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) .....

(State or country): Va.

14 Informant: Elizabeth Jackson

(Address): 509 Walton St

15 Filed: C. HAMPSON JONES, M. D. Registrar

Per XXX

231929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/24/29 19

17 I HEREBY CERTIFY, That I attended deceased from April 19 29 to May 24 19 29

that I last saw him alive on May 20, 19 29

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Toxemia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Cardiac Edema

(duration) yrs. 3 mos. 4 ds.

18 Where was disease contracted

If not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) John H. Lafayette M. D.

19 (Address) 1012 N. Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — Date of Burial: May 24 1929

20 UNDERTAKER: John H. Trader — ADDRESS 1027 Druid Hill Ave

Information should be carefully supplied. All questions should be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46187

CERTIFICATE OF DEATH

31

E 46187

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 1133 N Carrollton Ave (ST.) 23 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Cora Stith

(a) RESIDENCE NO. 1133 N Carrollton ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Major Stith

6 DATE OF BIRTH (month, day, and year): 1904

7 AGE — Years: 25 | Months: | Days: | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Prince George Co. Md.

PARENTS

10 NAME OF FATHER: General Stines

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Major Stith

(Address): 1133 N Carrollton

15 Filed MAY 23 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 21 29

17 I HEREBY CERTIFY, That I attended deceased from Apr. 5, 1929 to May 21, 1929

that I last saw her alive on May 21, 1929

and that death occurred, on the date stated above, at 9-15 a m.

The CAUSE OF DEATH* was as follows:

(Bronchial)Pneumonia.

And acute Nephritis

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Tuberculosis

Dont know (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Dont know

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. White, M. D.

19 (Address) 1029 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Petersburg Va — DATE OF BURIAL: May 23 1929

20 UNDERTAKER: Samuel W Hensley — ADDRESS: 578 N Bridge

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46188

CERTIFICATE OF DEATH

101-001

E 46188

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 2005 McCulloh St. (Ward) 14-20

2-FULL NAME Mabel G. Waddell

(a) RESIDENCE 2005 McCulloh St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 5 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Female	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of No.

6 DATE OF BIRTH (month, day, and year) Dec 18-1928

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
		5	3 4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Butts Md
(State or country)

PARENTS

10 NAME OF Edgar W Waddell

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md
(State or country)

12 MAIDEN NAME OF MOTHER Mercia E Carter

13 BIRTHPLACE OF MOTHER (city or town) Butts Md
(State or country)

14 Informant Mercia E. Waddell
(Address) 2005 McCulloh

15 Filed ..... 19.. C. HARRISON JONES, M. D. Registrar

MAY 23 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry,) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Where was disease contracted If not at place of death? home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) Harry Funk M. D.

May 23 29 (Address) Coroner.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem — DATE OF BURIAL: May 25 29

20 UNDERTAKER Samuel J Kemsley — ADDRESS 1 N Bond

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should sign CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 46189

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46189

CERTIFICATE OF DEATH

159-02

1—PLACE OF DEATH

REGISTERED NO. 97-56

CITY OF BALTIMORE: (No. 3203 W. Virginia Ave. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Arnold

(a) RESIDENCE NO. 3203 W. Virginia Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 22, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
				15 Min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Henry J. Arnold

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Ellie Webb

13 BIRTHPLACE OF MOTHER (city or town) Fairport
(State or country) Virginia

14 Informant Mr. Henry J. Arnold
(Address) 3203 W. Virginia Ave.

15 Filed MAY 26 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22, 1929

17

I HEREBY CERTIFY, That I attended deceased from MAY 22 1929, 19..., to MAY 22 1929, 19...,

that I last saw her alive on MAY 22 1929, 19...

and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Congenital heart disease

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Ernest M. Rahn, M. D.

5/23, 19 29 (Address) 3005 W. North Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Westminster Md	May 24 19 29
20 UNDERTAKER Fort & Cook	ADDRESS 1005 West Baltimore St

important. See instructions on back of certificates.

Cor.—16-10-29—A Co.—100 Bks.

E 46190

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46190

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Johns Hopkins Hospital St., 7-9 Ward)

2-FULL NAME John S. Maloney

(a) RESIDENCE NO. Little Rock Ark. St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Eloise Maloney

6 DATE OF BIRTH (month, day, and year) Aug 1879

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	49	9		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Insurance
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) South Carolina

PARENTS

10 NAME OF FATHER Stephen Maloney

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary A. ------

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Unknown

14 Informant Robt. M. Butterfield
(Address) Little Rock, Ark.

15 Filed ....., 19.... THOMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23/29 192

17. I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Brain Tumor-(Malignant)

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? .....

Did an operation precede death? yes Date of May 22/29

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) E. E. Vaiden, M. D.

5/23 19 29 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Little Rock Ark	May 23 1929
20 UNDERTAKER	ADDRESS
John O Mitchell	1900 Eutaw place.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAY 28 1929

Spec.–7-17-26—A Co.—200 Bks.

E 46191

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001

E 46191

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 27-43 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Schaumloeffel

(a) RESIDENCE NO. 2912 Evergreen Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S. if of foreign birth? 47 yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nettie Schaumloeffel

6 DATE OF BIRTH (month, day, and year) July 10/65

7 AGE	Years	Months	Days	IF LESS than 1 day ____ hrs. or ____ min.
63	63	10	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) France

PARENTS

10 NAME OF FATHER Daniel Schaumloeffel

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany.

12 MAIDEN NAME OF MOTHER Zinn?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) France

14 Informant Nettie Schaumloeffel

(Address) 2912 Evergreen Ave

15 Filed ____, 19 ____ Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-22 1929

17 I HEREBY CERTIFY, That I attended deceased from 5-15, 1929, to 5-22, 1929, that I last saw him alive on 5-22, 1929, and that death occurred, on the date stated above, at 7.05 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemorrhage

(duration) ____ yrs. ____ mos. 10 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) ____ yrs. ____ mos. 3 ds.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Nelson Carey, M. D.

, 19 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem Date of Burial May 25 1929

20 UNDERTAKER Philip Herwig ADDRESS 2016 Orleans

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 46192 HEALTH DEPARTMENT—CITY OF BALTIMORE E 46192

CERTIFICATE OF DEATH

117

1—PLACE OF DEATH — REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. So. Balto. Gen. Hospital ST., _____ WARD)

2—FULL NAME James Lowry

(a) RESIDENCE NO. 2116 E. Eutaw ST., _____ WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Lowry

6 DATE OF BIRTH (month, day, and year) August 8 1859

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
69 yrs. ~~11 ds~~	9	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) — 462

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Elsie Lowry
(Address) 2222 E. Biddle St

15 Filed _____, 19 _____ WM. C. RAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22/29

17 I HEREBY CERTIFY, That I attended deceased from May 16, 1929, to May 22, 1929, that I last saw him alive on May 22, 1929, and that death occurred, on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis Peritonitis

1 week.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of May 16, 1929

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) E. A. Lukenger, M. D.

, 19 (Address) So Balto Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cem — DATE OF BURIAL May 24 1929

20 UNDERTAKER Philip Herwig — ADDRESS 2016 Orleans St

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bka.

E 46193

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46193

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3102 Beverly Road ST., 8-40 WARD)

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary A. A. Hood

(a) RESIDENCE NO. 3118 (Usual place of abode) Mareco Ave ST., WARD

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: LeRoy E. Hood

6 DATE OF BIRTH (month, day, and year): Apr 5 75

7 AGE: Years 54 | Months 1 | Days 16 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer): 69

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Conrad H. Herrmann

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Louise Mehr

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: LeRoy E. Hood

(Address): 3118 Mareco Ave

15 Filed 19 Per Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 21/29

17 I HEREBY CERTIFY, That I attended deceased from 5/14, 1929, to 5/21, 1929, that I last saw her alive on 5/21/29 and that death occurred, on the date stated above, at 5 30 A m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis & nephrolithiasis

(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary): Acute cardiac dilitation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Lee Magness M. D.

5/21, 1929 (Address) 120 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Mem.

DATE OF BURIAL: 5/23 19 29

20 UNDERTAKER: Philip Herring

ADDRESS 2016 Orleans St.

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46194

REGISTERED NO. E 46194

1-PLACE OF DEATH

City of Baltimore: (No.) 17 E. Fayette St. (St.) 47-55 (Ward) 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles H. Gerwig.

(a) RESIDENCE NO. 6204 Biltmore Ave. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White.

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, HUSBAND of Elizabeth C. Gerwig.

6 DATE OF BIRTH (month, day, and year): March 9, 1866

7 AGE — Years: 68 — Months: 2 — Days: 11 — IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Contractor & Builder.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town): Howard Co. Md.
(State or country)

PARENTS

10 NAME OF FATHER: Charles Gerwig.

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Maryland.

12 MAIDEN NAME OF MOTHER: Mary Pfeiffer.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Maryland.

14 Informant: J. Raymond Gerwig. (son)
(Address) 6209 Biltmore Ave.

15 Filed ..., 19.. HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 20, 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

Acute dilatation of the Heart.

(duration) ... yrs. ... mos. ... da.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Eberhardt, M. D.

5/21, 1929 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: May 23 1929

20 UNDERTAKER: W. M. Coulson — ADDRESS: 1338 W. North

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill out CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46195

CERTIFICATE OF DEATH

129

E 46195

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 15 10 W. Mulberry ST., 19-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Lurton Richardson

(a) RESIDENCE NO. 1510 W. Mulberry ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of George Richardson

6 DATE OF BIRTH (month, day, and year) not known

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in whirh employed (or employer) c/o

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Anne Arundel Co. Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Louisa Grayson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Anne Arundel Co. Maryland

14 Informant Geo. Richardson
(Address) 1510 W. Mulberry

15 Filed 1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-22-29

17 I HEREBY CERTIFY, That I attended deceased from Nov 10, 1928, to May 22, 1929, that I last saw h[er] alive on May 21, 1929 and that death occurred, on the date stated above, at 4.30 a.m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 1 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) hepatitis

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs & Symptoms

(Signed) John G. T. Chandler, M. D.

. 19 (Address) 924 N. Carrollton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	May 24, 1929
20 UNDERTAKER Mrs Katie R. Williams	ADDRESS 3225 Schroeder St

important. See instructions on back of certificates.

HY 23197

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

46196 CERTIFICATE OF DEATH

20 26 E 46196

REGISTERED NO.

City of Baltimore: (No.) Mercy Hospital. (St.) 26-1 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Michael Toth.

(a) RESIDENCE NO. 4808 Eastern Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	White.	Married.

5a If married, HUSBAND of Mary Toth.

6 DATE OF BIRTH (month, day, and year) October 2, 1879

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	49	7	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Riveter
(b) General nature of industry, business, or establishment in which employed (or employer) Bartlett Hayward Co,
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Hubgary.

PARENTS

10 NAME OF FATHER Michael Toth.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Hungary

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Hungary

14 Informant Mary Toth.(wife)
(Address) 4808 Eastern Ave.

Filed MAY 23 1929 HAMILTON JONES, M. D. Registrar
BY Kilk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:
Fracture of the Pelvis.
Caught under a falling sheet of metal. Accidental Death.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Scott & Pratt Sts.
Did an operation precede death? No. Date of May 21, 1929
Was there an autopsy? No.
What test confirmed diagnosis? Inquiry
(Signed) Stoll & Fennandt, M. D.
5/28 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemet. DATE OF BURIAL May 24 1929

20 UNDERTAKER Louis Heymann ADDRESS 32 S Broadway

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46197

CERTIFICATE OF DEATH

100-001

E 46197

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1837 N. Spring ST., 9-18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Albert Faulkner

(a) RESIDENCE NO. 1837 N. Spring ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. 5 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb. 17. 29

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
		3	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Jesse Watson

11 BIRTHPLACE OF FATHER (city or town) ~~Baltimore~~
(State or country) Charlotte Co. Va.

12 MAIDEN NAME OF MOTHER Estelle Faulkner

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Mecklenburg Co. Va.

14 Informant Estelle Faulkner
(Address) 1837 N. Spring

15 Filed [illegible] C. HARRISON JONES, M. D.
Registrar

AY 231929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22. 29

17 I HEREBY CERTIFY, That I attended deceased from May 12, 1929, to May 22, 1929, that I last saw him alive on May 22, 1929, and that death occurred, on the date stated above, at 8:40 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys Exa

(Signed) W. L. Berry, M. D.

, 19 (Address) 1420 E. Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	May 23 1929
20 UNDERTAKER Jno. M. Johnson	ADDRESS 1234 Ethan St.

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46198

CERTIFICATE OF DEATH

31 E 46198

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS

REGISTERED NO.

CITY OF BALTIMORE: (No. [illegible] ST. (or WARD) 42-36

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Grace Matthews

(a) RESIDENCE NO. 509 Stump Alley ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 37

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Isaiah Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 [illegible] Informant

(Address)

15 Filed [illegible], 19[illegible] [illegible] M. D. Registrar

MAY 23 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 18, 1929, to May 20, 1929.

that I last saw her alive on May 20, 1929

and that death occurred, on the date stated above, at 11:45 A. m.

The CAUSE OF DEATH* was as follows:

multiple fibromyomata of uterus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) old Tuberculosis of retroperitoneal glands (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) Warren H. Wheeler M. D.

19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Zion Ct	May 23 1929
20 UNDERTAKER S. L. Brown's Son	ADDRESS 1810 Druid

IF DEATH OF [illegible] important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 46199

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31

E 46199
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 409 W. Hamburg St. St., 21-31 Ward

2-FULL NAME Louise Sorrell. (C)

(a) RESIDENCE NO. 409 W. Hamburg St. St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	Married.

5a If married, [redacted] (or) WIFE of Orrie Sorrell. (C)

6 DATE OF BIRTH (month, day, and year) June 8, 1907

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	21	11	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Virginia.

PARENTS

10 NAME OF FATHER Samuel Pettiford. (C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia.

12 MAIDEN NAME OF MOTHER Louise Rich. (C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia.

14 Informant Louise Pettiford. (C) mother
(Address) 409 W. Hamburg St.

15 Filed MAY 23 1929 HAMILTON JONES, M. D. Registrar
By Kaye

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto Steinhardt, M. D.

5/28. 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Ct. — DATE OF BURIAL May 24 19

20 UNDERTAKER S. L. Brown's Son — ADDRESS [illegible]

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN must state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46200

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001 E 46200

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3137 E. McElderry ST., 7-11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph J. Eahill

(a) RESIDENCE NO. 3137 E. McElderry ST., 7th WARD
(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 11 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
57 58		5	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Produce Dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Daniel Eahill

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Frances Doyle

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Leon Eahill (Nephew)
(Address) 3137 E. McElderry St.

15 Filed MAY 25 1929 Wm. H. JONES, M. D. Registrar

important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22nd 1929

17 I HEREBY CERTIFY, That I attended deceased from May 18 29, 19 29, to May 22 29, 19 29, that I last saw h alive on May 22 19 29, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Solar Crowning

CONTRIBUTORY (Secondary) Cerebral Edema (duration) yrs mos 9 ds.

(duration) yrs mos 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Pending

(Signed) Wm. H. Jones M. D.

1929 (Address) 500 N. Wolfe St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL May 25 1929

20 UNDERTAKER Lilly-Gilardi Inc.

ADDRESS 403 S. Wolfe St

Spec.—1-10-21—M&T—1500 Bks.

46201

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001 E 46201

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 173 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Fisher

(a) RESIDENCE No. 922 S. Kenwood Ave ST. 1 WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 9-25-28

7 AGE — Years: — Months: 7 Days: 24 If LESS than 1 day, hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Samuel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mary Fisher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 MAY 29 1929 C. HAMPSON JONES, M. D. Registrar

Dep. RCC

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-22-1929

17 I HEREBY CERTIFY, That I attended deceased from 5-21 .1929. to 5-22 .1929.

that I last saw h[illegible] alive on 5-22 .1929.

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

1a Bronchopneumonia

b

c

d

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Rickets

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. exam

(Signed) [illegible]

, 19 (Address) Johns Hopkins Hospital, M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel Cem

DATE OF BURIAL: May 24th 1929

20 UNDERTAKER: Lilly & Sons Inc.

ADDRESS: 400 E. Hoffman

mation should be carefully supplied. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46202

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 46202

1—PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO.

CITY OF BALTIMORE: (No. ST 20-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jane C. Rhodes

(a) RESIDENCE NO. 524 Edgewood ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Aug 20, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	9	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records of

(Address) Baltimore City Hospitals

15 [illegible] HAMILTON JONES, M. D.
Registrar

AY 231929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 30, 1925 to May 22, 1929,

that I last saw her alive on May 22, 1929

and that death occurred, on the date stated above, at 2:00 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Senility

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Emphysema, Chronic myocarditis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) [illegible] M. D.

, 19 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	May 25 19 29
20 UNDERTAKER	ADDRESS
Geo. A. Smith	Baltimore

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 46203 5474 HEALTH DEPARTMENT—CITY OF BALTIMORE E 46203

CERTIFICATE OF DEATH.

32

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 17-24 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Williams

(a) RESIDENCE NO. 806 Druid Hill ave ST., ... WARD N.C.

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 20 1927

7 AGE Years 1 Months 7 Days 2, 11 If LESS than 1 day, hrs. or min. 18

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. Car

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Linda Clayton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S.C

14 Informant (Address) Records JOHNS HOPKINS HOSPITAL

15 Filed MAY 23 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 1929

17 I HEREBY CERTIFY, That I attended deceased from May 19, 1929, to May 22, 1929, that I last saw her alive on May 22, 1929, and that death occurred, on the date stated above, at 5.50 P m.

The CAUSE OF DEATH* was as follows:

Tuberculous meningitis

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) J. C. Goodwin, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pt. Auburn

DATE OF BURIAL May 23 29

20 UNDERTAKER J. Carl A. Bidden

ADDRESS 430 W. Biddle St

MAY 23 1929

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION should be entered, whether wife, widow, or widower. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 4620[illegible]

CERTIFICATE OF DEATH.

161-001

E 46204

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1521 Vine St. St. 19-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Baby Girl Colbert.

(a) Residence No. ..... St., ... Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) 5-19-29.

7-AGE. ..... yrs. ..... mos. 1 ds.

If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md

PARENTS.

10-NAME OF FATHER, Lewis Ellis

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER, Dorothy Colbert

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Washington D.C.

14-

(Informant) .....

(Address) .....

15-

Filed MAY 23 1929 H. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 5-20-29

17- I HEREBY CERTIFY, That I attended deceased from 5-19 1929 to 5-20 1929

that I last saw her alive on 5-20 1929

and that death occurred, on the date stated above, at 2.45 P m.

The CAUSE OF DEATH* was as follows:

Prematurity (36 Wks.)
Twin

(Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Frank T. Rouse M. D.

5/21 1929 (Address) Mount Hope

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. JOHNS HOPKINS HOSPITAL

DATE OF BURIAL. ..... 19..

20-UNDERTAKER. Commissioner Health

ADDRESS MAY 23 1929

For Wm. E. WOODALL

in plain terms, so that it may be properly classified. Exact statement of cause of death is required. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46205 — CERTIFICATE OF DEATH — 161-001 — E 46205

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2120 Oak ST. 12-51 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

REGISTERED NO.

2—FULL NAME Baby girl Reed

(a) RESIDENCE NO. 2120 Oak ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 0 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 5/22/29

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
0	0	0	4 hrs. 10 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Merve Hubbard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Clara Reed

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Georgia

14 Informant mother

(Address) JOHNS HOPKINS HOSPITAL

15 Filed MAY 23 1929 — HARRISON JONES, M. D. Registrar

3606

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 22, 1929, to May 22, 1929 that I last saw her alive on May 22, 1929 and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) M. Alexander Norris, M. D.

, 19 (Address) 15 E 16 Madison

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Health Dept.

DATE OF BURIAL 19

UNDERTAKER Commissioner Health

ADDRESS MAY 23 1929

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46206

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46206

23

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. St Josephs Hosp ST., 2-W WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sister Mary Concheta

(a) RESIDENCE NO. 724 South Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Sister

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Sept 31-1903

7 AGE: Years 25 | Months 7 | Days 22 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sister 065

(b) General nature of industry, business, or establishment in which employed (or employer): St Stanislaus Parish

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Milwaukee. Wis

PARENTS

10 NAME OF FATHER: Joseph Mirza

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland.

12 MAIDEN NAME OF MOTHER: Rozalie Muza

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland.

14 Informant: Rev A M Fuglewski

(Address): 724 S Ave

15 Filed 5-31-1929 H. HAMPSON JONES, M. D. Registrar

M. D. SIGNATURE REQUIRED

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 22-29

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1929, to May 22, 1929, that I last saw her alive on May 22, 1929, and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Encephalitis Lethargica

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Respiratory Failure (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A Shipton, M. D.

5-22-1929 (Address) St Josephs Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Stanislaus Cem DATE OF BURIAL: May 27 1929

20 UNDERTAKER: George A. Weber ADDRESS: 705 S Ann St

Important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

2 E 46207 HEALTH DEPARTMENT—CITY OF BALTIMORE E 46207

12:05 PM

CERTIFICATE OF DEATH. X 49

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. 7-9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hickman Jarrett

(a) RESIDENCE NO. Blue Sulphur Springs ST., WARD W. Va.
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male
4 COLOR OR RACE: white
5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1852

7 AGE: Years 77; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: farmer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): W Va

PARENTS

10 NAME OF FATHER: James Jarrett

11 BIRTHPLACE OF FATHER (city or town) (State or country): W. Va

12 MAIDEN NAME OF MOTHER: Elza Hickman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Rands

14 Informant: Mrs Susan Woods
(Address): Niagara Falls N.Y.

15 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23 1927

17 I HEREBY CERTIFY, That I attended deceased from May 16. 1929. to May 23, 1929. that I last saw him alive on May 23, 1929, and that death occurred, on the date stated above, at 12:05 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of prostate

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. 1 (?) mos ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Aug. 3. 1927

Was there an autopsy? No

What test confirmed diagnosis? Biopsy.

(Signed) G. B. Hubel. M. D.

, 19 (Address) Johns Hopkins Hospital. Baltimore Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Blue Sulphur Springs W. Va.

DATE OF BURIAL: May 24 1929

20 UNDERTAKER: Chas. O. Mitchell & Sons

ADDRESS: Union Place

Y 231929

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 46208 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 46208

REGISTERED NO. 22-43

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5615. Birchwood Ave (WARD)

2-FULL NAME James. E. Linton

(a) RESIDENCE NO. 5615. Birchwood Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Adelaide Linton

6 DATE OF BIRTH (month, day, and year): April 20-1887

7 AGE: Years 42. Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Mechanic.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Westminster Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant (Address): Edward. Rice 2409. Lafayette Ave.

15 C. HAMPSON JONES, M. D. Registrar

Y 23 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 22 1929

17 I HEREBY CERTIFY, That I attended deceased from May 11 1929 to May 22 1929

that I last saw him alive on May 22 1929

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Edema

1 hr.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Myocarditis.

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Harry McCarty M. D.

5 22 1929 (Address) 31 W Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery DATE OF BURIAL: May 25 1929

20 UNDERTAKER: Fred A. Krause & Son ADDRESS: 703 N

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 46209

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

E 46209

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 1611 North Ave (St.) Longwood (Ward) 15-60

2-FULL NAME Henry Bascom Kennard

(a) RESIDENCE No. 2716 W North Ave St., Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs 3 mos 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Cornelia Kennard

6 DATE OF BIRTH (month, day, and year) Feb 8 - 1858

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	71	3	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Joshua Kennard

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Julia Wyatt

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Cornelia Kennard
(Address) 2716 W North Ave

15 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) May 22nd 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to h... death (Inquest, autopsy or inquiry) on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) A. J. Finch, M. D.

May 23rd 1929 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemt	May 24 1929
20 UNDERTAKER Partam & Gore 1723 W Lafayette	ADDRESS

tion should be carefully supplied. AGE should be stated EXACTLY. If unknown, OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Y 231929

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46210

CERTIFICATE OF DEATH

90 V

E 46210

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 55 E. Randall ST. 23-3rd WARD

2—FULL NAME Katherine Murray

(a) RESIDENCE NO. 55 E. Randall ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Jas. Murray

6 DATE OF BIRTH (month, day, and year) Oct. 15 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	70	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Thos. Norton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant John J. Murray (Son)
(Address) 55 E. Randall St

15 Date 1929 C. HAMPSON JONES, M. D. Registrar

Y 231929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22-1929

17 I HEREBY CERTIFY, That I attended deceased from August 13, 1928, to May 22, 1929, that I last saw h.R alive on May 22, 1929 and that death occurred, on the date stated above, at 9 p. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis,

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P. S. & S.

(Signed) John V. Sezerbachin, M. D.

(Address) 1738 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem.	May 26 1929
20 UNDERTAKER Margaret H. Flynn	ADDRESS 1422 Light St.

important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 46211 HEALTH DEPARTMENT—CITY OF BALTIMORE E 46211

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

Registered No.

City of BALTIMORE: (No. 1508 N. Hollins St. 19-28 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Sarah Ellen McCoskery

(a) Residence No. 1508 W. Hollins St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-~~Single, Married, Widowed, or Divorced,~~ (Write the word) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Charles M. McCoskery

6-DATE OF BIRTH (month, day and year) Oct 29-1854

7-AGE, 74 yrs. 6 mos. 22 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Frederick Co Md

PARENTS.

10-NAME OF FATHER Samuel Crawford

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Frederick Co. Md

12-MAIDEN NAME OF MOTHER, Mary Ann Clay

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Frederick Co Md

14-

(Informant) Mrs Jennie Crawford

(Address) 1508 N. Hollins St

15-

Filed C. HAMPSON JONES, M. D. Registrar.

Y 231929

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). May 21-1929

17- I HEREBY CERTIFY, That I attended deceased from Aug. 1928 to May 21, 1929, that I last saw h. alive on May 21, 1929, and that death occurred, on the date stated above, at 6.25 P.M.

The CAUSE OF DEATH* was as follows:

Hypertrophied & enlarged Heart - Nephritis

(Duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) -

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? -

(Signed) W. J. Costello, M. D.

, 19 (Address) 335 E 31st St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt Olivet Cem Frederick Md — DATE OF BURIAL, May 24/29

20-UNDERTAKER, Harry J. Weitzel — ADDRESS 1581 N Howard St

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46212 CERTIFICATE OF DEATH 113 **E 46212**

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 103 South Monroe ST. 19-28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thomas A Parks Jr

(a) RESIDENCE NO. 103 South Monroe ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6 DATE OF BIRTH (month, day, and year) March 16 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Thomas A Parks

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Margaret Hammond

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Margaret Parks

(Address) 103 South Monroe

15 Filed MAY 24 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23-29

17 I HEREBY CERTIFY, That I attended deceased from 5/16/29 19 to 5/23/29 19, that I last saw h alive on 5/23/29 19 and that death occurred, on the date stated above, at 4:45 m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) 1 wk 6 dy yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? None

(Signed) H. Jones, M. D.

5/24 1929 (Address) 710 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery — DATE OF BURIAL 5/25 1929

20 UNDERTAKER William Cook — ADDRESS 1217 E Read

Important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46213

CERTIFICATE OF DEATH.

170 ✓ E 46213

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Druid Hill Park St. H-24 Ward)

2-FULL NAME John P. Geiger

(a) RESIDENCE NO. 700 Park ave St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret M. Geiger

6 DATE OF BIRTH (month, day, and year): March 16 1881

7 AGE — Years: 48 — Months: 2 — Days: 6 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Income Tax Consultant

(b) General nature of industry, business, or establishment in which employed (or employer): Self

(c) Name of employer

9 BIRTHPLACE (city or town): Balt

(State or country): Md

PARENTS

10 NAME OF FATHER: J. M. Geiger

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Md

12 MAIDEN NAME OF MOTHER: Rosa Geiger

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Md

14 Informant: Margaret M. Geiger

(Address): 700 Park ave

15 Filed JUL 24 1925 19____ C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-22 1925

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gen. Shock caused by Shock right temple Suicide

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) John H. Jones M. D.

(Coroner)

5/23, 1925 (Address) 3232 Roland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount — Date of Burial 5 24 1925

20 UNDERTAKER: J. M. Cook — ADDRESS 1217 N. Cook

OF DEATH in plain terms, so that it may be properly very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46214

CERTIFICATE OF DEATH.

101-001

E 46214

1-PLACE OF DEATH St. Agnes Hospital

CITY OF BALTIMORE: (No. Caton & Wilkens Ave ST. 71-29 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Ada Hopkins

(a) RESIDENCE No. 1345 Glydon Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): widow

5a If married, widowed, or divorced HUSBAND of or) WIFE of: George W Hopkins

6 DATE OF BIRTH (month, day, and year): March 5. 1871

7 AGE: Years 58 | Months 2 | Days 14 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: At Home

9 BIRTHPLACE (city or town) (State or country): Penna.

PARENTS

10 NAME OF FATHER: John Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Geo. John Taylor

(Address) 1345 Glydon Ave

MAY 24 1929 C. HAMILTON JONES, M. D. Registrar

Wit

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5-22 1929

17

I HEREBY CERTIFY, That I attended deceased from 5-20, 1929, to 5-22, 1929,

that I last saw her alive on 5-22, 1929,

and that death occurred, on the date stated above, at 5-50 a.m.

The CAUSE OF DEATH* was as follows:

Myocarditis - endocarditis

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Lobar pneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam + History

(Signed) [illegible], M. D.

, 19 (Address) St Agnes Hosp. Balto Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross, Mobby

DATE OF BURIAL: May 26 1929

20 UNDERTAKER: J. H. Cook

ADDRESS: 2114 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified.

TION is very important See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

Euries Brown.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46215

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

100-801

E 46215

REGISTERED NO.

CITY OF BALTIMORE: (No. 1624 Mosher St 16-22 STR. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Euries Brown

(a) RESIDENCE. NO. 1624 Mosher St ST.. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: col

5 Single, Married, Widowed, or Divorced (write the word): Sing'l

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct 17-1927

7 AGE — Years: 1 — Months: 7 — Days: — If LESS than 1 day, hrs. or min.: 5-

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Wm Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Lena Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Lena Brown

(Address): 1624 Mosher St

Filed ... 19 ... HAMILTON JONES, M. D., Registrar

By ...

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 22/29

17 I HEREBY CERTIFY, That I attended deceased from May 21, 1929, to May 22, 1929, that I last saw him alive on May 22, 1929, and that death occurred, on the date stated above, at 12.55 P m.

The CAUSE OF DEATH was as follows:

Broncho Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): acute dilatation Heart

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? no Date of none

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Chas A Fettinger, M. D.

, 19 (Address) 1807 W Fayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn

DATE OF BURIAL: 5-24 29

20 UNDERTAKER: Daniel Eichas

ADDRESS 716 Ca

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

241929

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46216

CERTIFICATE OF DEATH

21 ✓ E 46216

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 1605 N. Mount ST., 15-21 WARD)

2—FULL NAME Richard Mallard

(a) RESIDENCE NO. 1605 N. Mount ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1909

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
20	19			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butler 070

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Hays Mallard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hanover, Va.

12 MAIDEN NAME OF MOTHER Mary Palmer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Hanover, Va.

14 Informant Evelyn Mallard
(Address) 415 E. 24th St

15 MAY 24 1929 [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-21-29

17 I HEREBY CERTIFY, That I attended deceased from 4-15-, 19 29, to 5-21-, 19 29, that I last saw h[illegible] alive on 5-20-, 19 29, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary T. B.

(duration) yrs. 2 wks ds.

CONTRIBUTORY (Secondary) Pulmonary Congestion

(duration) yrs. 3 wks ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) [illegible] M. D.

, 19 (Address) 1605 N. Mount St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
[illegible] Cem	5-24 1929
20 UNDERTAKER [illegible]	ADDRESS [illegible]

important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

46217

HEALTH DEPARTMENT—CITY OF BALTIMORE

181-002

E 46217

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. University Hospital 15-16 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Opher

(a) Residence No. 1038 W. Saratoga St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Colored

5-Single, ~~Married~~, Widowed, ~~or Divorced~~, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July 5, 1912

7-AGE, 16 17 yrs. 10 mos. 14 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, professiou, or particular kind of work. Domestic

(b) General nature of Industry, business, or establishment in which employed (or employer). 070

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), Md.

PARENTS.

10-NAME OF FATHER, George Clark

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Taylor Island Md

12-MAIDEN NAME OF MOTHER, Annie Opher

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Taylor Island Md

14- (Informant) Annie Opher Cornish

(Address) Taylor Island md

15-

Filed MAY 24 1929 192 C. HARRISON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 5-19-29

17- I HEREBY CERTIFY, That I attended deceased from 4-4-29 19 to 5-19 19 29.

that I last saw her alive on 5-19 19 29

and that death occurred, on the date stated above, at 2 30p m.

The CAUSE OF DEATH* was as follows:

1 Cerebral Embolism

Contributory Carcinoma of Cervix

(Duration) yrs. mos. ds

CONTRIBUTORY (Secondary) Carcinoma of Cervix

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edward J. Kavanaugh M. D.

5/20 19 29 (Address) Emer. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Cambridge, Md. DATE OF BURIAL. May 24, 1929

20-UNDERTAKER. Mrs Katie R. Williams ADDRESS 322 Schroeder St

in plain terms, so that it may be properly classified. Exact statement of cause of death is necessary. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46218

CERTIFICATE OF DEATH

31 E 46218

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST. 21-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME May Jones

(a) RESIDENCE NO. 1116 Burgundy st. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 31

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George Deeker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie Deeker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed MAY 24 1929 19 H. McC. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 22, 1929, to May 23, 1929, that I last saw her alive on May 23, 1929 and that death occurred, on the date stated above, at 10.40 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculous laryngitis

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical and lab.

(Signed) Henry C. Smith, M. D.

5-23-1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem

DATE OF BURIAL 5/25 1929

20 UNDERTAKER Edward Jonson

ADDRESS 2359 Wash Blvd

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46219 HEALTH DEPARTMENT—CITY OF BALTIMORE E 46219

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1522 W Lafayette ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edward Walter Giles

(a) RESIDENCE NO. 1522 W Lafayette ST., WARD (If non-resident give city or town and State)
(Usual place of abode)

Length of residence in city or town where death occurred 84 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma B. Giles

6 DATE OF BIRTH (month, day, and year) Oct 2 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	7	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Financier

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Walter Giles

11 BIRTHPLACE OF FATHER (city or town) (State or country) Plymouth England

12 MAIDEN NAME OF MOTHER Ann Emma Wells

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Halifax N. S.

14 Informant Mrs Emma Giles Tucker

(Address) 1522 W Lafayette

15 [illegible] C. HAMPSON JONES, M. D. Registrar

Y 241929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21-1929

17 I HEREBY CERTIFY, That I attended deceased from [illegible] 19 29, to May 21, 19 29

that I last saw h alive on May 21, 19 29

and that death occurred, on the date stated above, at 11:40 A m.

The CAUSE OF DEATH* was as follows:

Cardio-arteriosclerosis (coronary)

Cerebral hemorrhage

Pneumonia Duration yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

Duration yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) [illegible] M. D.

, 19 (Address) 704 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
London Park Cem	May 24 29
20 UNDERTAKER Wm L. Tickner & Sons	ADDRESS N. & Pa

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46220

CERTIFICATE OF DEATH

× 185 ✓

E 46220

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 4-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lina Taylor

(a) RESIDENCE NO. 319 Second St. ST. Laurel WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 13 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Benjamin C Taylor

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE: Years 57 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: C. H. Bichue

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Dewey Taylor

(Address) Laurel Md.

15 Filed MAY 24 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 23 1929

17 I HEREBY CERTIFY, That I attended deceased from April 30, 1929 to May 23, 1929

that I last saw her alive on May 23, 1929

and that death occurred, on the date stated above, at 8.30 P m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia, secondary to fracture of left hip (Cancer)

(duration) yrs. mos. 2-3 ds.

CONTRIBUTORY (Secondary): Broncho pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical course of case

(Signed) C. H. Verne M. D.

5-23-1929 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Md

DATE OF BURIAL: May 25 1929

20 UNDERTAKER: Harry A. Shipley

ADDRESS: 1531 Sth Lombard St Balto

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 46221 HEALTH DEPARTMENT—CITY OF BALTIMORE **E 46221**

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No. 15-64 ST.) (WARD) 90

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph A. Rose

(a) RESIDENCE NO. 3805 Edgerton Rd WARD
(Usual place of abode)
Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? ? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sophia Rose

6 DATE OF BIRTH (month, day, and year): Apr. 7, 1843

7 AGE — Years: 86 — Months: 1 — Days: 15 — If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): Cattle Dealer
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany.

PARENTS
10 NAME OF FATHER: Aaron Rose
11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany
12 MAIDEN NAME OF MOTHER: Unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. S. Rose
(Address) 3805 Egerton Rd.

15 Filed MAY 24 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/22/1929

17 I HEREBY CERTIFY, That I attended deceased from 4/7, 1929, to 5/22, 1929, that I last saw him alive on 5/22, 1929, and that death occurred, on the date stated above, at 11:45 P m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration
(Arteriosclerotic)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Meyer Miller, M. D.

, 19 (Address) Sinai Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Hebrew Cemt — DATE OF BURIAL: 5/24/1929

20 UNDERTAKER: David Sondheim — ADDRESS: 10-12 W. Mt. Royal Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46222 HEALTH DEPARTMENT—CITY OF BALTIMORE E 46222

CERTIFICATE OF DEATH

1—PLACE OF DEATH N.W. Charles + Monument Hts 46 REGISTERED NO.

CITY OF BALTIMORE: (No. 4 Washington Apts ST. 11-2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Regina Stayes Jenkins

(a) RESIDENCE NO. Washington Apts ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. ? mos. ? ds. How long in U. S., if foreign birth? 56 yrs. 2 mos. 14 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Alex. F. Jenkins

6 DATE OF BIRTH (month, day and year): March 8 1873

7 AGE — Years: 56 | Months: 2 | Days: 14 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Ceciltown Maryland

PARENTS

10 NAME OF FATHER: Richard Stayes

11 BIRTHPLACE OF FATHER (city or town) (State or country): not known

12 MAIDEN NAME OF MOTHER: Mary Stayes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): not known

14 Informant: Mr. Alex. F. Jenkins (Ruland)

(Address): Washington Apts

15 Filed MAY 24 1929 19 WM. H. JONES, M. D. Registrar

Important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 22 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 1928, to May 22 1929, that I last saw her alive on May 22 1929, and that death occurred, on the date stated above, at 6:45 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma - Primary in Uterus

Recently at Delivery Jan 1928 with Subinvolution & Obstruction by Dr. Finney (duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Cardiac Anemia

(duration) yrs. 1 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 5/6/29

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) J. Wesley Cole, M. D.

5/23 1929 (Address) 2702 Guilford

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: May 24 1929

20 UNDERTAKER: Stewart & Conner Co — ADDRESS: Bale

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46223

CERTIFICATE OF DEATH

E 46223

1—PLACE OF DEATH

REGISTERED NO. 211

CITY OF BALTIMORE: (No. 3114 E Monument St., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Christian Blenkner

(a) RESIDENCE NO. 3114 E Monument St., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie B. Haddox

6 DATE OF BIRTH (month, day, and year) Nov 16-1878.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	6	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Peter Blenkner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dora Lange

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Minnie B Haddox

(Address) 3114 E Monument St

15 Filed MAY 24 1929 19 H. M. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22-1929

17 I HEREBY CERTIFY, That I attended deceased from Feby 1 1929, to May 22 1929, that I last saw him alive on May 22 1929, and that death occurred, on the date stated above, at 4 20 P m.

The CAUSE OF DEATH* was as follows:

Cancer of Stomach

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Feby 1929.

Was there an autopsy? Yes

What test confirmed diagnosis? Exploration

(Signed) Harry McCarty M. D.

May 23 1929 (Address) 37 W Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL May 23 1929

20 UNDERTAKER John Merrick

ADDRESS 2008 Aliceanna

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46224

CERTIFICATE OF DEATH

31

E 46224

1—PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO. 16-2

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Daniel Noonan

(a) RESIDENCE NO. 3207 E. Baltimore ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Orderly

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

086

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Noonan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Eliza McGee

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Records of

(Address) Baltimore City Hospitals

15 Filed MAY 24 1929 H. LAMOND JONES, M. D., Registrar

Per R.B.C.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 22, 1929, to May 22, 1929.

that I last saw him alive on May 22, 1929

and that death occurred, on the date stated above, at 11:30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

Unknown (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no What test confirmed diagnosis? Physical Exam

(Signed) Warren H. McClean, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cem	May 25, 1929
20 UNDERTAKER John Welch	ADDRESS 2008 Aliceanna

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46225

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46225

31

1—PLACE OF DEATH

REGISTERED NO. 15-64

CITY OF BALTIMORE: (No. 3906 Maine Ave ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank L. Moran.

(a) RESIDENCE NO. 3906 Maine Ave ST., Forest Park WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — Catherine Moran.

6 DATE OF BIRTH, (month, day, and year) May 24 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	30	11	30.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrician

(b) General nature of industry, business, or establishment in which employed (or employer) /

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER James D. Moran.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Elizabeth Lowe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Carolina.

14 Informant Mrs. Elizabeth Moran

(Address) 3906 Maine Ave.

15 Filed ..., 19... Registrar

C. HAMILTON JONES, M. D.

AY 241929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23rd 1929.

17

I HEREBY CERTIFY, That I attended deceased from April 30, 1929, to May 23, 1929, that I last saw him alive on May 22, 1929 and that death occurred, on the date stated above, at 12 30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis.

(duration) 2 yrs. mos. ds.

18 Where was disease contracted — If not at place of death?

Did an operation precede death? — Date of

Was there an autopsy? /

What test confirmed diagnosis? /

(Signed) Wm Flemer, M. D.

5/24/29 (Address) 3405 Gannon

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem.	May 25th 1929
20 UNDERTAKER	ADDRESS
John J. Cowan & Son	901 Baltimore

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46226

CERTIFICATE OF DEATH

129 E 46226

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 410 S Monastery ST., 70-11 WARD)

2—FULL NAME Margaret L Fraey

(a) RESIDENCE NO. 210 S Monastery Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of John L Fraey

6 DATE OF BIRTH (month, day, and year) June 15 1881

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
47	11	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John F Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Elizabeth Flaig

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant John L Fraey

(Address) 210 S Monastery Ave

15 Filed MAY 24 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 14, 1927, to May 23, 1929

that I last saw h alive on May 23, 1929

and that death occurred, on the date stated above, at 12:50 a m.

The CAUSE OF DEATH* was as follows:

Cardiac dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis, Interstitial (duration) 1 yrs. 11 mos. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) James L Kemp M. D.

5/31 1929 (Address) 1729 N Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	5/27/29
20 UNDERTAKER	ADDRESS
Geo A Tuley Fulton & Fayette	

Important. See instructions on back of certificate.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46227

CERTIFICATE OF DEATH.

E 46227

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 420 Maudlan ST. (POTEE) WARD) 25-15

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fran M. Patee

(a) RESIDENCE NO. 420 Maude ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James E. Patee

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER Hugh Dugley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Gallagher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant James E. Patee

(Address) 420 Maudlan

15 241929 C. HAMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1929

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1929, to May 23, 1929,

that I last saw her alive on May 23, 1929,

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of uterus

(duration) Indefinite yrs. mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of April 5/29

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. C. R. Campbell M. D.

(Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem. Washington D.C. Via Canton

DATE OF BURIAL May 27 1929

20 UNDERTAKER John F. Denny

ADDRESS 715 Lightner

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 46228

HEALTH DEPARTMENT—CITY OF BALTIMORE E 46228

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Stanley

(a) RESIDENCE NO. Meyersdale Pa ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lumberman

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa —

PARENTS

10 NAME OF FATHER Louis Stanley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa +

12 MAIDEN NAME OF MOTHER Anna Hansen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa —

14 Informant Friends — (Address) JOHNS HOPKINS HOSPITAL

15 MAY 24 1929 C. HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23 1929

17 I HEREBY CERTIFY, That I attended deceased from May 15 1929 to May 23 1929 that I last saw him alive on May 23 1929 and that death occurred, on the date stated above, at 2.35 P m.

The CAUSE OF DEATH* was as follows:

Brain Tumor

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of 15 May 29

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) Ben S Massey M. D.

5/24 1929 (Address) Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Myersdale. Penna.

DATE OF BURIAL May 24 1929

20 UNDERTAKER Henry Sander & Sons Inc

ADDRESS Baltimore St & Broadway.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Moran

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46229

CERTIFICATE OF DEATH

E 46229

1—PLACE OF DEATH

REGISTERED NO. 20-69 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 405 East Lynn Ave. ST. WARD)

2—FULL NAME Edward Moran

(a) RESIDENCE NO. 405 East Lynn Avenue ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary J. Moran

6 DATE OF BIRTH (month, day, and year) March 25, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	1	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER William Moran

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mr. Albert A. Moran

(Address) 405 East Lynn Ave.

15 Filed MAY 24 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1929, to May 23, 1929, that I last saw him alive on May 23, 1929 and that death occurred, on the date stated above, at 6.15 A. m.

The CAUSE OF DEATH* was as follows:

Cerebro Thrombosis

Bronchopneumonia / Rheumatic / Senility

(duration) Unknown

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Nathan C. Kline, M. D.

May 24 1929 (Address) 2151 Wilkens Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery

DATE OF BURIAL May 25 19 29

20 UNDERTAKER Wm. H. Cook

ADDRESS 1003 West Baltimore St.

...21—M&T—1500 Bks.

E 46230

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 46230

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital (St.) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Smyth

(a) RESIDENCE NO. 935 Sharp St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Black

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Newborn Infant

6 DATE OF BIRTH (month, day, and year) 5/20/29

7 AGE Years Months Days If LESS than 1 day, 5 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Newborn Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt, Md

PARENTS

10 NAME OF FATHER Charles Wood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Emma Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address)

15 MAY 24 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/20 1929

17

I HEREBY CERTIFY, That I attended deceased from 5/20/29 12 m. 1929, to 5/20/29 12 m. 1929.

that I last saw h[illegible] alive on 5/20/29, 1929,

and that death occurred, on the date stated above, at 12 00 noon m.

The CAUSE OF DEATH* was as follows:

Premature Infant.

Twin

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) James T. Longstaff, M. D.

5/21, 1929 (Address) Mercy Baby Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

MAY 24 1929

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 46231

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 46231

REGISTERED NO. 161

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hosp. ST. 23-31 WARD

2-FULL NAME Infant Baby Boy Smith

(a) RESIDENCE NO. 935 Sharp St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years | Months | Days: 1 | If LESS than 1 day // hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Newborn Infant

(b) General nature of industry, business, or establishment in which employed (or employer): Premature

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balt Md

PARENTS

10 NAME OF FATHER: Sylvester Wood

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not known

12 MAIDEN NAME OF MOTHER: Ena Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant (Address)

15 C. HAMPSON JONES, M. D. Registrar

Per ROCK 6609

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/21 1929

17 I HEREBY CERTIFY, That I attended deceased from 5/20, 1929, to 5/21, 1929.

that I last saw h[illegible] alive on 5/21/29, 19...,

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Newborn Infant

Premature

32 mths gestation

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) [illegible] M. D.

(Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

MAY 24 192

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MAY 24 1929

UNIVERSITY OF MARYLAND

Spec.—2-29-28—L. F. S.—500 Bks.

E 46232

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 29

E 46232

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Lemmon's Hospital, St., Ward) 30

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Irvin Smith

(a) RESIDENCE NO. Manchester Md

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if foreign birth? yrs. mos. ds.

WARD

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 9 1918

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	10	3	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Emory H Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Julia Kiler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Emory H Smith

(Address) Manchester Md

15 Filed C. HAMPSON JONES, M. D. Registrar

Y 241029

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24, 1929

17

I HEREBY CERTIFY, That I attended deceased from May 20. 1929. to May 24. 1929.

that I last saw h[illegible] alive on May 24 1929

and that death occurred, on the date stated above, at 2:50 P. m.

The CAUSE OF DEATH* was as follows:

Tetanus

over

CONTRIBUTORY (Secondary) Puncture wound, right foot (duration) yrs. mos. 15 ds.

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Curtis C. Hoodless M. D.

. 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Manchester Md

DATE OF BURIAL 5/28 1929

20 UNDERTAKER H Bankard & Son

ADDRESS Westminster Md

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46233

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-91

E 46233

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3602 E, Pratt ST. 76-37 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Louis S Sessa

(a) RESIDENCE NO. 3602 E, Pratt ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 10 mos. 2 ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Baby

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 21st 1926

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Gaetano Sessa

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Mary Miccio

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14

Informant Frank Sessa

(Address) 3602 E, Pratt St.

15

Filed 24 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-23-29

17

I HEREBY CERTIFY, That I attended deceased from 5-16-, 1929, to 5-23, 1929, that I last saw h alive on 5-22, 1929 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH was as follows:

Acute Lobar Pneumonia

CONTRIBUTORY (Secondary) acute Lobar Pneumonia (duration) yrs. mos. 7 ds.

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) S Amarco M. D.

5-23, 1929 (Address) medical arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Most Holy Redeemer

DATE OF BURIAL: May 2 1929

20 UNDERTAKER: Frank V. Pipitone

ADDRESS: 2818 E, Balto St.

Important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46234

CERTIFICATE OF DEATH.

+ 90 E 46234

REGISTERED NO.

1-PLACE OF DEATH Church Home + Inf

City of BALTIMORE: (No. Broadway & Fairmount 64 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Heyer

(a) RESIDENCE NO. Wilmington N C Ward

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. — mos. 7 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Heyer

6 DATE OF BIRTH (month, day, and year) Sept. 20-1884

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	44	8	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lawyer

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Wilmington N C.

10 NAME OF FATHER Matt Heyer

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Va

12 MAIDEN NAME OF MOTHER Mary Bell

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Va

PARENTS

14 Informant Catherine Heyer

(Address) Wilmington N C

15 Filed C. THOMPSON JONES, M. D. Registrar

241929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24 1929

17 I HEREBY CERTIFY, That I attended deceased from May 17, 1929, to May 24, 1929, that I last saw h. i.m alive on May 23, 1929, and that death occurred, on the date stated above, at 2 a.m.

The CAUSE OF DEATH* was as follows:

Myocardial failure

CONTRIBUTORY (Secondary) Myocardial insufficiency (duration) yrs. mos. ds.

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Walter B. Johnson M. D.

May 1929 (Address) Church Home + Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wilmington N C. Date of Burial 5/27 1929

20 UNDERTAKER Hughes & Jones. ADDRESS 122 N Broadway

OF DEATH in Path (cards, so that they may be very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46235 ✓ **E 46235**

CERTIFICATE OF DEATH.

129

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1732 Ashburton ST. 15-6 WARD)

2-FULL NAME Mary Alice Totten

(a) RESIDENCE. No. 1732 Ashburton ST., ... WARD. .....

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 21. 191[illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	15	0	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Muncie
(State or country) Indiana

PARENTS

10 NAME OF FATHER Francis E. Totten

11 BIRTHPLACE OF FATHER (city or town) Indiana
(State or country)

12 MAIDEN NAME OF MOTHER Lydia Poole

13 BIRTHPLACE OF MOTHER (city or town) W. Va
(State or country)

14 Informant Francis E. Totten
(Address) 1732 Ashburton St.

15 Date received [illegible] G. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24 1929

17

I HEREBY CERTIFY, That I attended deceased from Dec. 25, 1928. to May 24, 1929.

that I last saw her alive on May 24, 1929.

and that death occurred, on the date stated above, at 3:35 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis
Rickets

about (duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) W. H. Triplett, M. D.

, 19 (Address) 1324 W. Lombard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Morgantown W. Va — DATE OF BURIAL: May 27 19[illegible]

20 UNDERTAKER: Mc Mrs. John W. Teufel & Son — ADDRESS: 801 W. Fayette

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Y 241929

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46236

CERTIFICATE OF DEATH

74 001 E 46236

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 312 N. Ellwood Ave. St. 6-11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME CAPTAIN DANIEL O. CAULK

(a) RESIDENCE NO. 312 N. Ellwood Ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Raee	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Gertrude F. Caulk

6 DATE OF BIRTH (month, day, and year) August 18, 1862

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
	66	9	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mariner

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 6 years

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Dawson Caulk

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret Dumefer

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Mrs. Elizabeth McNichols (Daughter)

(Address) 312 N. Ellwood Ave.

MAY 24 1929

C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23 19 29

17 I HEREBY CERTIFY, That I attended deceased from Nov. 19 28 to May 23 19 29

that I last saw him alive on May 22 19 29

and that death occurred, on the date stated above, at 2:20 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis (cerebral)
Hemiplegia - 7 mos

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos 3 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Joseph Toulney M. D.

, 19 (Address) 800 N. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
St. Michael's Cemetery
Talbot County, Maryland.

Date of Burial May 26 19 29

20 UNDERTAKER Henry Sander & Sons. Inc.

ADDRESS BALTIMORE ST. & BROADWAY.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46237 HEALTH DEPARTMENT—CITY OF BALTIMORE E 46237

CERTIFICATE OF DEATH

57

1—PLACE OF DEATH — REGISTERED NO. 6-11

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST. (or WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Otto Gritzner

(a) RESIDENCE NO. 12 N. Streeper st. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if foreign birth? Unknown yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth k. Gritzner

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Can tester

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Otto Gritzner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Bertha Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Records
(Address)

15 Filed MAY 24 1929, 19 C. HAMPSON JONES, M. D. Registrar
By ARR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 13, 1929, to May 24, 1929,

that I last saw him alive on May 24, 1929

and that death occurred, on the date stated above, at 10.50 a. m.

The CAUSE OF DEATH* was as follows:

Senility

Diabetes mellitus

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical an autopsy

(Signed) Henry C. Smith M. D.

5-24 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel Cemetery — DATE OF BURIAL: May 27, 1929

20 UNDERTAKER: Henry Sander & Sons. Inc. — ADDRESS: BALTIMORE ST. & BROADWAY.

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46238

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

48

E 46238

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Balto. City Hosp ST. 20-28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Geo. Reynolds

(a) RESIDENCE NO. 2034 Hollins ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida Reynolds

6 DATE OF BIRTH (month, day, and year) [illegible] 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
37	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Electrician

(b) General nature of industry, business, or establishment in which employed (or employer) 029

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Richard Reynolds

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Mary E. Hagner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mary E. Reynolds

(Address) 3 Hollins St

15 C. HAMPSON JONES, M. D. Registrar

241929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/22/29

17 I HEREBY CERTIFY, That I attended deceased from 5/16, 1929, to 6/22, 1929, that I last saw h[illegible] alive on 6/22, 1929 and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma left side of face with ulceration

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. M. Lumpkin, M. D.

6/22, 1929 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL [illegible] DATE OF BURIAL 6/25 1929

20 UNDERTAKER [illegible] ADDRESS 38 Eighth Ave

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

Edward Szekalski

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46239

CERTIFICATE OF DEATH

1827

E 46239

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Found - Harbor

City of Baltimore: (No. Fort Carolina St., 1-3 Ward)

2-FULL NAME Edward Szekalski

(a) RESIDENCE NO. 2129 Cambridge St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 20. 1917

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	9	5	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Walter Szekalski

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland

12 MAIDEN NAME OF MOTHER Alice Kuczinski

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland

14 Informant Walter Szekalski
(Address) 2129 Cambridge St

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Fort Carolina

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Autopsy case

(Signed) James A Fenton, M. D.

5. 24. 1927 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stanislaus Kostka — DATE OF BURIAL 26 1927

20 UNDERTAKER John M Weber — ADDRESS 911 N Chester St

Y 24 1929

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill out OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 46240

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46240

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: (No. Caton & Wilkens Aves ST., 15-63 WARD)

REGISTERED NO. 161-61

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Boy Boy Winter

(a) RESIDENCE NO. 3908 W Garrison Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
male	white	

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of

6 DATE OF BIRTH (month, day, and year) 5/24/29

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
1 hour			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Joseph L Winter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mo.

12 MAIDEN NAME OF MOTHER Myrtle H Dorsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Father - Joseph L Winter

(Address) 3908 W Garrison Ave.

15 Filed C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24 1929

17

I HEREBY CERTIFY, That I attended deceased from 12 50 pm 5-23 1929 to 2 25 AM 5-24 1929, that I last saw him alive on 5-24- 1929, and that death occurred, on the date stated above, at 2 25 A m.

The CAUSE OF DEATH* was as follows:

1 Miscarriage

(duration) yrs mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Goldstein M. D.

19 (Address) At [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Druid Ridge Cemetery

DATE OF BURIAL May 27 1929

20 UNDERTAKER Harry R. Armacost

ADDRESS 4204 Ridgewood Ave

Y 241929

CAUSE OF DEATH in plain terms, so that it may be properly CODED. ATTENTION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 46241

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46241

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL (ST.) 7-9 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Lazear

(a) RESIDENCE (No.) Wheeling W. Va ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jane-Lazear.

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Postal Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) W. Va

PARENTS

10 NAME OF FATHER Wm

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Sarah Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) Records JOHNS HOPKINS HOSPITAL

15 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24 1929

17

I HEREBY CERTIFY, That I attended deceased from May 21, 1929, to May 24, 1929, that I last saw him alive on May 24, 1929, and that death occurred, on the date stated above, at 6.45 P m.

The CAUSE OF DEATH* was as follows:

Brain Tumor, Benign

(duration) yrs. 15 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of May 1929

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) I. Redgway Trimble M. D.

May 25 1929 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Sistersville - W. Va. DATE OF BURIAL May 25 1929

20 UNDERTAKER John S. Mitchell ADDRESS 1900 Eutaw Place

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of ... TION is very important. See instructions on back of certificates.

MAY 24 1929

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

Bauer

CERTIFICATE OF DEATH

E 46242

90 E 46242

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2036 Harford Ave St. 9-4b Ward)

2-FULL NAME Barbara Bauer

(a) RESIDENCE NO. 2036 Harford Ave St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of John H. Bauer Sr.

6 DATE OF BIRTH (month, day, and year) Dec 28/1858

7 AGE Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
70	4	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Casper Kramer

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant John H. Bauer
(Address) 2036 Harford Ave

15 Filed ...19... C. HAMPSON JONES, M. D. Registrar
Per

Y 25 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Probably Chr Myocarditis

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature], M. D.

5/24/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bolton Cemetery — DATE OF BURIAL 5/27/29

20 UNDERTAKER William Cook — ADDRESS 1217 N Paul

tion should be carefully supplied. Age should be stated in OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46243

E 46243

CERTIFICATE OF DEATH

129

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 807 Cedarcroft Rd. ST. 27-48 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Amelia Louisa Kiel

(a) RESIDENCE NO. 807 Cedarcroft Rd. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if foreign birth 46 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (Write the word)
Female	White	Widowed

a If married, widowed, or ~~divorced~~ ~~Husband of~~ (or) WIFE of Geo.A.Kiel

6 DATE OF BIRTH (month, day, and year) Jan. 21/1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	4	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Adolph Popp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr Wm. Woelm

(Address) 809 Cedarcroft Rd.

15 MAY 29 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23/1929

17 I HEREBY CERTIFY, That I attended deceased from 5-19, 1929, to 5-23, 1929

that I last saw her alive on 5-23, 1929

and that death occurred, on the date stated above, at 8.50 P.M.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J. Lovell, M. D.

5-24, 1929 (Address) 406 W. Lexington St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	May 27/1929
20 UNDERTAKER Philip Herwig	ADDRESS 2016 Orleans St.

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 46244

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31

E 46244

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St. N-2 Ward)

2-FULL NAME Herman Stoll

(a) RESIDENCE NO. 3222 E. Lombard St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Sophie Stoll

6 DATE OF BIRTH (month, day and year) Feb. 5 - 1891

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
38	3	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Hat bleacher
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER Ferdinand Stoll

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany.

14 Informan: Sophie Stoll
(Address) 3222 E. Lombard St

15 Filed MAY 25 1929 16 C. HAMPSON JONES, M. D. Registrar
BY [illegible]

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tuberculous Broncho-pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Edgar Zadek M. D.

5/23. 1929. (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Cem DATE OF BURIAL May 25 1929

20 UNDERTAKER Philip Henrig ADDRESS 206 Oakmont

NOTICE—AGE should be carefully supplied. PHYSICIANS should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-28—A Co.—300 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46245

CERTIFICATE OF DEATH.

E 46245

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) University Hospital St. 4-30 (Ward)

2-FULL NAME John Englehart

(a) RESIDENCE NO. Dorsey Md St._____ Ward_____

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 22 mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anne M Englehart

6 DATE OF BIRTH (month, day, and year) Feb 17 1851

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	78	3	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Englehart

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mrs Rovena Cassady

(Address) Dorsey md

MAY 25 1929 C. HAMPSON JONES, M. D. Registrar

Burial ORH

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of right femur.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Eugene Gilbert M. D.

(Coroner)

5/25, 1929 (Address) 2139 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? Dorsey, Md.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Zion Cemetery Howard Co Md May 26 1929

20 UNDERTAKER John F Denny ADDRESS 715 Light

(For information as to preparing this certificate, see reverse side. Exact statement of OCCUPATION is very important. See instructions on back of certificate.)

Spec.—2-29-28—L. F. S.—500 Bks.

E 46246

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46246

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3722 E. Pratt ST. 16-31 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Robert Kenneth Keller

(a) RESIDENCE NO. 3722 E. Pratt ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 11 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 26-1928.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	10	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Robert Keller.

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Adah A. Swanner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14

Informant Robert Keller

(Address) 3722 E Pratt St

15

Filed C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24-1929

17

I HEREBY CERTIFY, That I attended deceased from May 5 1929 to May 24 1929.

That I last saw him alive on May 22 1929

and that death occurred, on the date stated above, at 8.45 a m.

The CAUSE OF DEATH* was as follows:

Pneumococcic Peritonitis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Morris S. Schmidlapp M. D.

, 19 (Address) 1514 Eastern Ave - City

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem

DATE OF BURIAL May 27 1929

20 UNDERTAKER John Allen

ADDRESS 200 E Lexington

Important. See instructions on back of certificate.

7 25 1929

Spec.—2-29-28—L. F. S.—500 Bks.

E 46247

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

91-002

E 46247

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 808 N Rose ST., 7-12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Albert Herman Schreiber.

(a) RESIDENCE NO. 808 N Rose ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Catherine Schreiber

6 DATE OF BIRTH (month, day, and year): 2/18/1847

7 AGE: Years 82 Months 3 Days 5 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Merchant retired

(b) General nature of industry, business, or establishment in which employed (or employer): 20 years.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Charles Schreiber

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Dora Lenz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Rose Koenig

(Address) 808 N Rose St

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.

251929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 23 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1929 to May 23 1929

that I last saw him alive on May 23 1929

and that death occurred, on the date stated above, at 3 45 a m.

The CAUSE OF DEATH* was as follows:

arteriosclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Louis Krause M. D.

19 (Address) 702 S. Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem

DATE OF BURIAL: May 26 1929

20 UNDERTAKER: John Aleich

ADDRESS: 2008 Aliceanna

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46248

CERTIFICATE OF DEATH

101-001

E 46248

1—PLACE OF DEATH

REGISTERED NO. 16-25

CITY OF BALTIMORE: (No. 1109 N. Calhoun ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Witherspoon, Jr.

(a) RESIDENCE NO. 1109 N. Calhoun ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. 9 mos. 7 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 17, 1921

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	7	9	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md.

PARENTS

10 NAME OF FATHER John Witherspoon

11 BIRTHPLACE OF FATHER (city or town) Los Angeles
(State or country) Calif.

12 MAIDEN NAME OF MOTHER Amelia Johnson

13 BIRTHPLACE OF MOTHER (city or town) King Co.
(State or country) Va.

14 Informant John Witherspoon
(Address) 1109 N. Calhoun St.

15 Filed MAY 25 1929 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/24/29

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1929 to May 24, 1929, that I last saw him alive on May 24, 1929 and that death occurred, on the date stated above, at 5 p.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Bi- lateral

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical exam.

(Signed) Walter J. Jackson, M. D.

, 19 (Address) 1631 E. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
W. Laurel	May 25 1929
20 UNDERTAKER	ADDRESS
Chas. H. Grove & Son	400 Mosher

Important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 46249

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46249

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 202 Division 14-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hortanse Gaines

(a) RESIDENCE. No. 202 Division ST., — WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Gaines

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years: 74 — Months: — Days: — If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Teamster

(b) General nature of industry, business, or establishment in which employed (or employer): Hauling

(c) Name of employer: Private Dept

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Benjamin Gaines

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Mrs M. L. Gaines
(Address) 202 Division

15 Filed May 25 1929 — C. HAMPSON JONES, M. D. Registrar

AKR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 23 1929

17 I HEREBY CERTIFY, That I attended deceased from March 15 1929 to May 23 1929

that I last saw h[illegible] alive on May 23 1929

and that death occurred, on the date stated above, at 2 p m.

The CAUSE OF DEATH* was as follows:

Right Hemiplegia - Caused by Coronary Thrombosis Heart Lesion

(duration) Hemiplegia 4 mos. 4 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 4 months ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) W. L. Coleman M. D.

(Address) 2039 McCulloh

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetary — DATE OF BURIAL: May 26 1929

20 UNDERTAKER: Thomas E. Kelson — ADDRESS: 1303 Pennsylvania Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF CONDITION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46250

CERTIFICATE OF DEATH

185

E 46250

1-PLACE OF DEATH

City of Baltimore: (No.) University Hospital St. 17-24 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Lee

(a) RESIDENCE NO. 636 George St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Lee

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	54			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Rukert Bros

9 BIRTHPLACE (city or town)
(State or country) N.C.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Mrs. Mary Lee
(Address) 636 George St.

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.

MAY 25 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23 - 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fractured Skull

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Block St. Warehouses

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edgar Zellers, M. D.

5-25. 1929 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Lowe Cemetery	May 26, 1929
20 UNDERTAKER	ADDRESS 2220
Mrs Kate R. Williams	Schroeder &

tion should be carefully supplied. Age should be stated in years. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 46251 HEALTH DEPARTMENT—CITY OF BALTIMORE E 46251

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Woman's Hospital REGISTERED NO. 87

CITY OF BALTIMORE: (No. 14-20 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachel Lieblich Siegel

(a) RESIDENCE No. Marlborough Apts St. Balto WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred entire life mos. ds. How long in U. S., if of foreign birth? Life mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	widowed

5a If married, widowed, or divorced (or) WIFE of Joseph Siegel

6 DATE OF BIRTH (month, day, and year) Dec. 21, 1915

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	13	5	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore.

PARENTS

10 NAME OF FATHER Marcus Lieblich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Clara Ring

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Gerald Siegel

(Address) Hotel Wilshire - Detroit Mich.

15 [illegible] 19 C. HAMPSON JONES, M. D. Registrar

MAY 25 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 1929

17 I HEREBY CERTIFY, That I attended deceased from April 25, 1929, to May 25, 1929,

that I last saw her alive on May 25, 1929,

and that death occurred, on the date stated above, at 12:15 A. m.

The CAUSE OF DEATH* was as follows:

myocardial failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) acute pericarditis (duration) 2 yrs. 1 mos. 6 ds.

18 Where was disease contracted if not at place of death? Marlborough Apts

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Dale P. Clemson M. D.

19 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Hebrew Cem	5/27/1929
20 UNDERTAKER Heid Sondheim	ADDRESS 410-20 W. Mt. Royal Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 46252

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46252

CERTIFICATE OF DEATH.

REGISTERED NO. 57

1-PLACE OF DEATH Franklin Square Hospital

CITY OF BALTIMORE: (No.) 9-116 ST., (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James D'angelo

(a) RESIDENCE NO. 2216 Hartford Road WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) 6/16/1908

7 AGE Years	Months	Days	If LESS than 1 day hrs. or min.
20	10 11	8	X

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Confectionery

(b) General nature of industry, business, or establishment in which employed (or employer) Store. 019

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Gioachino D'Angelo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Mary D'Antoni

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Samuel D'angelo

(Address) 2216 Hartford Rd.

15 Filed MAY 25 1929, 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-29 1929

17

I HEREBY CERTIFY, That I attended deceased from 5-22, 1929, to 5-23-, 1929, that I last saw h~~im~~live on May 23, 1929, and that death occurred, on the date stated above, at 10-15 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

Carbuncle Neck

(duration) 4 yrs mos ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 5-23-29

Was there an autopsy? No What test confirmed diagnosis? Clinically

(Signed) C. W. Leak M. D.

, 19 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem

DATE OF BURIAL 5/27/29, 19

20 UNDERTAKER George J Ruth

ADDRESS 1735 Harford

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of place of occurrence is very important. See instructions on back of certificates.

HAMPSON JONES M. D.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

46253

CERTIFICATE OF DEATH

E 46253

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital ST. (WARD)

2—FULL NAME Christ Xeros

(a) RESIDENCE NO. 506 S 13th St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Mal

4 COLOR OR RACE: Whit

5 Single, Married, Widowed, or Divorced, (write the word): Singl

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): 1893

7 AGE: 35 (36) Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: mill worker

(b) General nature of industry, business, or establishment in which employed (or employer): labor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Greece

PARENTS

10 NAME OF FATHER: Christ Xeros

11 BIRTHPLACE OF FATHER (city or town) (State or country): Greece

12 MAIDEN NAME OF MOTHER: Xeros

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Greece

14 Informant: James Xeros

(Address): 506 S. 13 st

15 Date: MAY 25 1929, 19 Registrar: C. HAMPSON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 24, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1929 to May 24, 1929, that I last saw him alive on May 24, 1929 and that death occurred, on the date stated above, at 12 30 A.m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia, right upper, middle & lower lobes.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical finding

(Signed) W. A. Varney, M. D.

5/27, 1929 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem'y.

DATE OF BURIAL: 5/27 1929

20 UNDERTAKER: Geo. L. Ruth

ADDRESS: 1735 Jackson

MAY 25 1929

important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 46254 HEALTH DEPARTMENT—CITY OF BALTIMORE E 46254

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1210 E Biddle ST. 10-14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elsie M. Wiedefeld

(a) RESIDENCE NO. 1210 E Biddle ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single~~, Married, ~~Widowed, or Divorced~~, (write the word)
F	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William H. Wiedefeld

6 DATE OF BIRTH (month, day, and year) May 1 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33	0	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER William H. Clifford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Hannah Roberts

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant William H. Wiedefeld (Address) 1210 E. Biddle St

15 Filed MAY 25 1929, 19 HAMPSON Jones M.D. Registrar

CAUSE OF DEATH to print items, See instructions on back of certificates. TION is very important

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24 1929.

17 I HEREBY CERTIFY, That I attended deceased from January 16, 1929, to May 24, 1929, that I last saw her alive on May 24 1929 and that death occurred, on the date stated above, at 1130 A.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) yrs. 9 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Typical Examination

(Signed) Albert C. Lanahan M. D.

5/24, 1929 (Address) 2025 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore County	May 28 1929

20 UNDERTAKER George F. Ruth ADDRESS 1225 Linden

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46255

CERTIFICATE OF DEATH.

49 E 46255

1-PLACE OF DEATH 1711 N. Broad st.

CITY OF BALTIMORE: (No. Mary V Shaughnessy ST., 8-17 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary V. Shaughnessy

(a) RESIDENCE NO. 1711 N. Broad. ST, WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 ~~Single~~, ~~Married~~, Widowed, ~~or Divorced~~, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Late Thomas V. Shaughnessy

6 DATE OF BIRTH (month, day, and year): Aug 5 1879

7 AGE: Years 50; Months 9; Days 4; If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laundress
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: John McGarvey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Ellen Dorsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mary V. Shaughnessy
(Address): 1711 N. Broad st

15 HAMPSON JONES, M. D.
Registrar

MAY 25 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 24 1929

17 I HEREBY CERTIFY, That I attended deceased from June 4, 1928, to May 24, 1929.
that I last saw h alive on May 24, 1929
and that death occurred, on the date stated above, at 3 A m
The CAUSE OF DEATH* was as follows:

Sarcoma R. Clavicle

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary): My married daughter

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X rays & Biopsy.

(Signed) J. H. Kenney, M. D.

, 19 (Address) 1518 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: May 28 1929

20 UNDERTAKER: Geo. L. Ruth — ADDRESS: 1730 Maryland Ave

CAUSE OF DEATH to be plainly written, so that it may be understood. See instructions on back of certificates. TION is very important

Spec.—1-10-21—M&T—1500 Bks.

E 46256 (704)

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 46256

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 3-4 WARD)

2-FULL NAME Cecelia Jenkins

(a) RESIDENCE NO. 1601 E Pratt St ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ——

6 DATE OF BIRTH (month, day, and year) May 10, 1909

7 AGE: Years 20; Months; Days 13; If LESS than 1 day, hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Stanley Jankowitz

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Margt Linney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 MAY 25 1929

G. HAMPSON JONES, M. D.

Per ——— Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23 19 29

17

I HEREBY CERTIFY, That I attended deceased from Mch 24, 1929, to May 23, 1929,

that I last saw h alive on ....., 19....,

and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 2 yrs mos ds.

CONTRIBUTORY (Secondary) Septicemia pneumococcus

(duration) yrs. mos. 17 ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of ——

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy.

(Signed) James Bordley, Jr. M. D.

May 27 1929 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery. DATE OF BURIAL: May 27 19

20 UNDERTAKER: George J. Roth ADDRESS: 1735 Hoffman

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause of death is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46257

CERTIFICATE OF DEATH.

129 E 46257

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1821 N. Rigester ST., 8-17 WARD)

2-FULL NAME Saffia D. Scheer.

(a) RESIDENCE NO. 1821 N. Rigester ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, ~~Married~~, ~~Widowed~~, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): May 1/1873

7 AGE: Years 56 | Months | Days 27 | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework.

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Frederick Scheer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Anna E. Bickel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Frederick Scheer.

(Address) 1821 N. Rigester st.

15 Filed ..., 19... C. HAMPSON JONES, M. D. Registrar

Per ...

MAY 251929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 23 1929.

17 I HEREBY CERTIFY, That I attended deceased from Feby 1 - 1929 to May 23 1929.

that I last saw h. alive on May 22 1929

and that death occurred, on the date stated above, at 9.00 a. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis
arterio-sclerosis
Hypertension.

(duration) yrs. 3 mos 23 ds.

CONTRIBUTORY (Secondary) Toxaemia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of —

Was there an autopsy? no

What test confirmed diagnosis? Microscopic.

(Signed) George Abner Bauden, M. D.

5/24 1929 (Address) 1517 E North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemty. DATE OF BURIAL: May 27 1929

20 UNDERTAKER: Geo. L. Rutt ADDRESS: 1735 Harford

CAUSE OF DEATH to be plainly written, so that it may be properly coded. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46258

CERTIFICATE OF DEATH

1851

E 46258

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St. 24-34 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Hartman

(a) RESIDENCE NO. 1704 Byrd St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	27			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Elevator builder
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Balto Car Wheel Co.

9 BIRTHPLACE (city or town)
(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Henry Hartman

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltomd

12 MAIDEN NAME OF MOTHER Annie Lear

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) New York

14 Informant Annie Hartman
(Address) 1704 Byrd St

15 Filed 25 1929, 19 THOMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry find that said deceased came to his death (Inquest, autopsy or inquiry) on the day stated above.

The CAUSE OF DEATH* was as follows:
Probable fracture
7th cervical vertebra

CONTRIBUTORY (Secondary) Shock (duration) yrs. mos. 1 ds.

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Curtis Bay

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zeller, M. D.

5/25, 1929 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem. DATE OF BURIAL 5/27 1929

20 UNDERTAKER John J Fahey Sons ADDRESS 1318 Light

tion should be carefully supplied. OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46259

CERTIFICATE OF DEATH

128 **E 46259**

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2235 Eastern ST., 3-4 WARD)

2—FULL NAME Peter Jones

(a) RESIDENCE NO. 2235 Eastern ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): May 10 1896

7 AGE: Years 33 | Months 0 | Days 13 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): D. C.

PARENTS

10 NAME OF FATHER: Unk

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unk

12 MAIDEN NAME OF MOTHER: Unk

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unk

14 Informant: Clara Green

(Address) 223 Eastern ST.

15 MAY 25 1929 Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 23 1929

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1929, to May 23, 1929, that I last saw h[illegible] alive on May 23, 1929 and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Nephritis
Subacute

(duration) yrs. mos. 13 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

May 24 1929 (Address) 508 [illegible] Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Mt. Calvary	May 25 1929

20 UNDERTAKER: Mrs Ida Snowden ADDRESS 1738 E. Madison St

important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46260 | CERTIFICATE OF DEATH | E 46260

118-09

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 9-13 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Barbara Rocacho

(a) RESIDENCE NO. 816 N Castle St St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married -

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Albert Rocacho

6 DATE OF BIRTH (month, day, and year): Not known

7 AGE: Years 57 Months Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer): 03

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Bohemia

PARENTS

10 NAME OF FATHER: Chas Gensky -

11 BIRTHPLACE OF FATHER (City or town) (State or country): Bohemia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bohemia

14 Informant: Albert Rocacho

(Address): 816 N Castle St

15 Filed: C. HAMPSON JONES, M. D. Registrar

Per

Y 251929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: May 24, 1929

17 I HEREBY CERTIFY, That I attended deceased from 5-23, 19 29, to 5-24, 19 29, that I last saw h alive on, 19, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Strangulated Femoral Hernia

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary): Intestinal obstruction

(duration) yrs. mos. 5 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of 5-23-29

Was there an autopsy?

What test confirmed diagnosis? Operation

(Signed) Melvin Carey -, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oakhill — Date of Burial: May 27 19 29

20 UNDERTAKER: Enoch Brockton — ADDRESS: 1900 Edmondson

tion should be carefully supplied. Age should be stated EXACTLY. Literal answers should be given to each question. Particular attention should be given to the CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 46261

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46261

1-PLACE OF DEATH

City of Baltimore: (No.) Balt City Hospital St. 25-77 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis Morgan

(a) RESIDENCE NO. 4817 Pennington Ave St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Willard Morgan

6 DATE OF BIRTH (month, day, and year) May 16, 1903

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
26		8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House work
(b) General nature of industry, business, or establishment in which employed (or employer) at home
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Maine

PARENTS

10 NAME OF FATHER Fred Fabian

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Mass.

12 MAIDEN NAME OF MOTHER Sarah Elwell

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maine

14 Informant Willard T. Morgan
(Address) 4817 Pennington Ave

15 Filed ..... 19 ..... HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Septicaemia following
Self Induced Abortion

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Septicaemia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? 4817 Pennington Ave.

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M. Tuttle, M. D.

5/24 1929 (Address) 7006 Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — DATE OF BURIAL May 27 1929

20 UNDERTAKER Harry N. Witzke — ADDRESS 53 N. Lombard St.

Not accepted by Co. Physician

Not accepted by Co. Physician

Not accepted by Co. Physician

Spec.—2-29-28—L. F. S.—500 Bks.

E 46262

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46262

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 660 W Fremont Ave ST.) WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry Brandenburg (Brandenburger)

(a) RESIDENCE NO. 2nd Davies Hotel ST. Baltimore City WARD)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 11 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed or Divorced, (write the word)
M.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Brandenburger

6 DATE OF BIRTH (month, day, and year) Sep. 10, 1866

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
63	1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shoemaker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Louis Brandenburg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Kremmer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Louise Brandenburg

(Address) 660 W Fremont Ave

15 [illegible], 19 HAMPSON JONES, M. D. Registrar

Y 251929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/24/29

17 I HEREBY CERTIFY, That I attended deceased from May 13, 1929, to May 24, 1929, that I last saw h[illegible] alive on May 24, 1929 and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia (acute)

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Cancer Stomach

(duration) ? yrs. mos. da.

18 Where was disease contracted if not at place of death? Hosp.

Did an operation precede death? Yes Date of May 20. 29

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Chalmers Cummings, M. D.

5/24, 1929 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New York City N. Y.	5/25 1929
20 UNDERTAKER Jack Lewis	ADDRESS 1439 E Balto St

Spec.—1-10-21—M&T—1500 Bks.

2 E 25-392
2 E 5-46263

HEALTH DEPARTMENT—CITY OF BALTIMORE E 46263

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 14-20 WARD) 139

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Blanch Andis

(a) RESIDENCE NO. 1611 McCulloh ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced, HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years: 38 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): U-Can-

PARENTS

10 NAME OF FATHER: Peter

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER: Mary

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant: Friends

(Address) JOHNS HOPKINS HOSPITAL

15 [illegible] 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 24 1929

17 I HEREBY CERTIFY, That I attended deceased from May 14, 1929, to May 24, 1929, that I last saw her alive on May 24, 1929, and that death occurred, on the date stated above, at 9 30 a. m.

The CAUSE OF DEATH* was as follows:

Myocarditis chronic
Peritonitis

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Myomata uteri

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balto

Did an operation precede death? yes Date of May 18/29

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) A Finkelstein M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Johnsons N. C. — DATE OF BURIAL: May 26 1929

20 UNDERTAKER: Mrs Geo. C. Holland — ADDRESS: 631 Dol.

MAY 25 1929

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF CONDITION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 46264

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46264

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 355 Font Hill ave ST. 20-69 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gertie. Buck

(a) RESIDENCE NO. 355 Font Hill ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, ~~Married~~, ~~Widowed~~, ~~or Divorced~~, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 25/29.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	—	—	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Roland Buck.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Snyder.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Roland Buck.

(Address) 355 Font Hill ave

15 Filed 19

C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 1929

17 I HEREBY CERTIFY, That I attended deceased from May 24, 1929, to May 25, 1929.

that I last saw her alive on May 25, 1929

and that death occurred, on the date stated above, at 5 9 m

The CAUSE OF DEATH* was as follows:

Pre-Mature infant
(1½ mo gestation)

(duration) yrs. mos ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? same

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Cl & Phy Exam

(Signed) Fred T. Kupper, M. D.

, 19 (Address) 3321 Fredericks Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery — DATE OF BURIAL: May 1929.

20 UNDERTAKER: Geo. F. Rust — ADDRESS: 1735 Harford ave

CAUSE OF DEATH must be plainly stated. See instructions on back of certificates.

V 251529

Spec.–7-17-26—A Co.—200 Bks.

E 46265

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

65-002 1/2

REGISTERED NO. E 46265

1-PLACE OF DEATH

City of BALTIMORE: (No. Md. Gen. Hospital Sec. 46-43 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter L. Rohrbaugh

(a) RESIDENCE NO. 5622 Pilgrim Rd. Ward Penna.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. 4 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 18, 1903

7 AGE — Years: 26 Months: 4 Days: 8

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Bank Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

009

9 BIRTHPLACE (city or town) Bordentown Pa.
(State or country)

PARENTS

10 NAME OF FATHER Calvin S. Rohrbaugh

11 BIRTHPLACE OF FATHER (City or town)
(State or country) Bordentown Pa.

12 MAIDEN NAME OF MOTHER Jessie Hammond

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Bordentown Pa

14 Informant Mrs. Roger Rohrbaugh
(Address)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 (19) 29

17 I HEREBY CERTIFY, That I attended deceased from Apr. 21, 1929, to May 26, 1929 that I last saw h alive on May 25, 1929 and that death occurred, on the date stated above, at 9.30 A m.

The CAUSE OF DEATH* was as follows:

Hodgkins Disease

(duration) yrs. 1 mos. 25 ds.

CONTRIBUTORY (Secondary) Cachexia due to Hodgkins Disease (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? yes Date of 4/30/29

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

(Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Glen Rock, Pa. Date of Burial 5/28 1929

UNDERTAKER G. W. Leiphardt Son ADDRESS New Rock, Pa.

MAY 27 1929

C. HAMILTON JONES, M. D.
Registrar

tion should be carefully supplied. Avoid abbreviations. Write plainly with pen and ink. Use only black or blue-black ink. Do not use pencil. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46266

CERTIFICATE OF DEATH.

135

E 46266
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hosp. ST. 3-4 WARD)

2-FULL NAME Harry Dubick

(a) RESIDENCE NO. 214 S. Bond ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? 19 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lena Libbick

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE: Years 78 — Months — Days — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Colney Dubick

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Fagell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant (Address): Philip Dubick 2602 Park Heights Terrace

15 Filed MAY 26 1929 19 Per C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-25 1929

17 I HEREBY CERTIFY, That I attended deceased from 4-18 1929 to 5-24 1929

that I last saw him alive on 5-25 1929

and that death occurred, on the date stated above, at 12:30 a. m.

The CAUSE OF DEATH* was as follows:

Prostatitis - Hypertrophic

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) P.O. Shock

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 5-24-29

Was there an autopsy? No

What test confirmed diagnosis? removal of prostate

(Signed) H. J. Rubenstein, M. D.

5/26 1929 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Southern Ave

DATE OF BURIAL: 5/26 1929

20 UNDERTAKER: Sol Levinson & Bro

ADDRESS 1127 E Baltimore St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of disease is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46267

CERTIFICATE OF DEATH

90 E 46267

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew age Home ST. 27-54 WARD)

2—FULL NAME Abraham Schwark

(a) RESIDENCE NO. Belvedere & Greenspring Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Rachael Schwark

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE: Years 80 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Tailor

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Estelle Schwark

(Address): 1402 W. Franklin St.

15 Filed ..... 19 ..... HAMILTON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/25/29

17

I HEREBY CERTIFY, That I attended deceased from April-2- 1929. to May-25- 1929 that I last saw h in alive on May 25 1929 and that death occurred, on the date stated above, at 10 a m.

The CAUSE OF DEATH* was as follows:

Myo-cardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? None.

(Signed) Herman Seidel M. D.

19 (Address) 2404 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rock Pk

DATE OF BURIAL: 5/26 1929

20 UNDERTAKER: Jack Lewis

ADDRESS: 1439 E. Balto St

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46268

1-PLACE OF DEATH

188-103

E 46268
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of Baltimore: (No. Johns Hopkins Hospital St., 7-10 Ward)

2-FULL NAME George E. Bronwell

(a) RESIDENCE NO. 603 N. Glover St., Ward
(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. 6 mos. 6 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 13/1915

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	14	0	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School Boy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Geo E. Bronwell

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Margaret Pfister

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto., Md.

14 Informant Geo. E. Bronwell
(Address) 603 N. Glover St

15 Filed ..., 19.. HAMPSON JONES, M. D. Registrar
By ...

MAY 26 1925

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:
Thoracic & abdominal Injuries
Accidently run over at autotruck
Balto. nr Broadway

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature] M. D.

5/25/29 (Address) 506 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
London Park Cemetery

DATE OF BURIAL
May 28th 1929

20 UNDERTAKER
George Schilling & Sons

ADDRESS

tion should be carefully supplied. ... OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Eks.

E 46269

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 46269

1-PLACE OF DEATH

City of BALTIMORE: (No. 5922 Bertram Ave St. 27-43 Ward) 29

Registered No.

2-FULL NAME Dr. Francis Davidson McCarrian

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 5922 Bertram Ave St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Eavanay McCarrian

6-DATE OF BIRTH (month, day and year) May 6, 1874

7-AGE. 55 yrs. — mos. 19 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Physician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country) Baltimore Md.

PARENTS.

10-NAME OF FATHER, James McCarrian

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto., Md.

12-MAIDEN NAME OF MOTHER, Bertha Beach

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto., Md.

14- (Informant) Mrs. Eavanay McCarrian

(Address) 5922 Bertram Ave

15- MAY 26 1929 E. HAMILTON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) May 25, 1929

17- I HEREBY CERTIFY, That I attended deceased from August, 1927 to May 25 1929 that I last saw him alive on May 24, 1929 and that death occurred, on the date stated above, at 9 21 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis + endocarditis

Arteriosclerosis + hyper-

tension — Chronic

nephritis (Duration) 2 yrs. 6 mos. ds

CONTRIBUTORY (Secondary) Myocardial Insuf-

ficiency (Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Evidence

(Signed) Geo. B. Sylvester M. D.

. 19 (Address) 2802 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL,
London Park	5/28/29
20-UNDERTAKER,	ADDRESS
[illegible] Cook	2[illegible] Fond Av

In plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Dr Forry
910 W Lombard

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46270

CERTIFICATE OF DEATH

129

E 46270

1—PLACE OF DEATH

REGISTERED NO. 19-28

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1509 Ramsey ST. WARD)

2—FULL NAME Sophia Fitsinger

(a) RESIDENCE NO. 1509 Ramsey ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of Conrad Fitsinger

6 DATE OF BIRTH (month, day, and year) Jan. 18-1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ht Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Elkridge
(State or country) Md

PARENTS

10 NAME OF FATHER Joseph Fritzinger

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Ahlborn

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant John J. Fitsinger
(Address) Arbutus Md

15 Filed MAY 26 1929, 19
Per
HARRISON JONES, M.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25-29

17 I HEREBY CERTIFY, That I attended deceased from 5/25/, 1924, to 5/25/, 1929,

that I last saw h alive on 5/25/29 1930 A.

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis
" Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Erysipelas

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Bernard J. Tracy, M. D.

5/25, 1929 (Address) 910 W Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mon Calvario

DATE OF BURIAL 5/28 1929

20 UNDERTAKER D. Will Cook

ADDRESS 1217 St Paul

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46271

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

91-002

E 46271

1—PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 6-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph Yentz

(a) RESIDENCE NO. 2037 Jefferson ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	84			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) ..... O H O

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records of

(Address) Baltimore City Hospitals

15 Filed MAY 26 1929 H. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24, 1929

17 I HEREBY CERTIFY, That I attended deceased from November 6, 19 19, to May 24, 19 29, that I last saw him alive on May 24, 19 29 and that death occurred, on the date stated above, at 6:30 A. m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis - Eczema Impetigo

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted ?, if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) Warren H. Cole, M. D.

, 19 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL E. Mathews

DATE OF BURIAL 5 27 19

20 UNDERTAKER W. Cook

ADDRESS 1212 Gay St

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46272

CERTIFICATE OF DEATH

118-002

E 46272
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 543 Mosher St. 14-20 Ward)

2-FULL NAME Robt Johnson

(a) RESIDENCE NO. 543 Mosher St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Arena Johnson

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	49			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 040
(c) Name of employer

9 BIRTHPLACE (city or town) Md.
(State or country)

PARENTS

10 NAME OF FATHER Sam Johnson

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Arena Johnson
(Address) 543 Mosher

15 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) May 28th 1929.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Intestinal Obstruction

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Regular

(Signed) [illegible] M. D.

May 28th 1929 Address Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	5-27 1929
20 UNDERTAKER	ADDRESS 916
Daniel Easton	Cayne

tion should be clearly supplied. Any [illegible] should be [illegible]
OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAY 26 1929

Spec.—1-10-21—M&T—1500 Bks.

E 46273 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

24-001

E 46273

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3357 ~ 4½ St. Brooklyn (St.) 25-75 (Ward)

2-FULL NAME Mack Gorum Gorum

(a) RESIDENCE NO. 3357 ~ 4½ St. Brooklyn ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary J. Gorum

6 DATE OF BIRTH (month, day, and year): 1868

7 AGE: Years 61; Months; Days; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): O'Neill

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): N C.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): N C

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N C.

14 Informant: Mary Gorum

(Address) 3357 ~ 4½ Brooklyn

15 C. HAMPSON JONES, M. D.

Registrar

Y 26 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 23 1929

17 I HEREBY CERTIFY, That I attended deceased from May 23, 1929, to May 24, 1929, that I last saw h. alive on May 24, 1929 and that death occurred, on the date stated above, at 4 P M.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ..... yrs. mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. O. Broode M. D.

5/24 1929 (Address) Brooklyn Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Calvary Cem — DATE OF BURIAL: 5-26 1929

20 UNDERTAKER: Dant Eston — ADDRESS 916 6a ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of DISEASE is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46274

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-002

E 46274

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 831 Park Ave ST., 11-25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Evelyn May Bayly Tiffany

(a) RESIDENCE NO. 831 Park Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: American white

5 ~~Single, Married~~, Widowed, ~~or Divorced~~, (write the word): Widow

5a ~~If married, widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of Dr Louis McLane Tiffany

6 DATE OF BIRTH (month, day, and year): April 13-1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	78	1	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Washington, D.C.

PARENTS

10 NAME OF FATHER: Thomas H. Bayly

11 BIRTHPLACE OF FATHER (city or town) (State or country): Accomack - Va.

12 MAIDEN NAME OF MOTHER: Evelyn Harrison May

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Petersburg, Va.

14 Informant: Emma C. Bleech

(Address) 831 Park Ave.

15 Filed MAY 28 1929 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 25th 1929

17 I HEREBY CERTIFY, That I attended deceased from Feby 3 1929, to May 25th 1929, that I last saw h.r alive on May 24 1929, and that death occurred, on the date stated above, at 7.30 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral thrombosis (hypertension)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Arteriosclerosis & Chronic Nephritis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) (M. D.

, 1929 (Address) 1813 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: TASLEY ACCOMAC Co Va

DATE OF BURIAL: 5-27-1929

20 UNDERTAKER: Henry W. Jenkins Sons Co

ADDRESS: Orchard McCullough

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46275 | CERTIFICATE OF DEATH | 139 E 46275

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) University Hospital St. 145-21 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Bertha Dasche

(a) RESIDENCE NO. 1819 N. Fulton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Moritz Dasche

6 DATE OF BIRTH (month, day, and year) Feb 29—1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	2	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Ella Sohle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Elka Lorenkery

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Moritz Dasche

(Address) 1819 N. Fulton Ave

15 Filed 5-26-29 CLAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-25-29

17 I HEREBY CERTIFY, That I attended deceased from 5-21, 1929, to 5-25, 1929, that I last saw her alive on 5-25, 1929, and that death occurred, on the date stated above, at 2.30 a m.

The CAUSE OF DEATH* was as follows:

Peritonitis, Paralytic Ileus following operation

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Uterine Febroid (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 5/23/29

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Joseph Laukaitis M. D.

5/25, 1929 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship

DATE OF BURIAL 5/28 19 29

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E Baltimore

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 46276

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46276

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Maryland Penitentiary. St. 10-15 Ward)

2-FULL NAME Joseph Alonzo Newman.(C)

(a) RESIDENCE NO. Feisterstown Md. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	~~Married~~ Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Do not know.

6 DATE OF BIRTH (month, day, and year): Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	35	----------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Barber and Cook.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country): Maryland.

PARENTS

10 NAME OF FATHER: William Newman.(C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Maryland.

12 MAIDEN NAME OF MOTHER: Ella Walker.(C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Maryland.

14 Informant: Ella Newman.(C)mother.
(Address) Newtown, Pa. Bucks Co.

15 Filed MAY 26 1929 C. HAMPSON JONES, M. D. Registrar
or

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 21, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.
Acute dilatation of the Heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Eisenhardt, M. D.

5/25. 1929 (Address) 101 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Reisterstown M E Church	May 27 1929
20 UNDERTAKER	ADDRESS
Samuel Dwight	864 Kara

tion should be carefully supplied. Age should be stated in years, months and days. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cora—12-9-25—A Co.—200 Bks.

E 46277

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 ✓ E 46277

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 711 Fields, St. 13-51 St., ____ Ward)

2-FULL NAME Mrs. Alexine Hood.

(a) RESIDENCE NO. 711 Fields, St. St. ____ Ward ____

(Usual place of abode)

(If non-resident give city or town and State) _____

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: white.

5 Single, Married, Widowed, or Divorced, (write the word): widow.

5a If married, widowed, or divorced HUSBAND of xxxx WIFE of --William Hood.

6 DATE OF BIRTH (month, day, and year) June, 17/1853.

7 AGE. Years: 75 Months: 11 Days: 7 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: at home.

PARENTS

9 BIRTHPLACE (city or town) Emmittsburg.

(State or country) Maryland.

10 NAME OF FATHER Jacob Neisher.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown.

14 Informant Mr. John Hood.

(Address) 1015 Rectory Lane.

15 Filed MAY 26 1929, 19 C. HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May, 24/1929.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry. (Inquest, autopsy or inquiry.) find that said deceased came to ____ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

5 hours

CONTRIBUTORY (Secondary) (duration) ____ yrs. ____ mos. ____ ds.

(duration) ____ yrs. ____ mos. ____ ds.

(Signed) ____ (Coroner) M. D.

MAY 25, 1929 (Address) 1532 Bolton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Marys Cem, Hampden. Date of Burial: 5/27/ 29.

20 UNDERTAKER: J. Walter Davis. ADDRESS 3307. Paine. St.

(If not properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.)

Spec.—2-29-28—L. F. S.—500 Bks.

Swain

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46278

CERTIFICATE OF DEATH

129

E 46278

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3512 W. Franklin ST. 20-70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie Parker Swain

(a) RESIDENCE NO. 3512 W. Franklin ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James F. Swain

6 DATE OF BIRTH (month, day, and year) Nov. 27, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	6	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER (Unknown) Parker

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Mrs. Agnes S. Turner

(Address) 3512 W. Franklin St.

15 Filed May 26 1929 C. HAMPSON JONES, M. D. Registrar

Per Book

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24, 1929

17 I HEREBY CERTIFY That I attended deceased from May 18, 1929, to May 24, 1929, that I last saw her alive on May 24, 1929, and that death occurred, on the date stated above, at 2:15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Chronic Endocarditis

Arteriosclerosis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) C. H. Wesley, M. D.

5/25, 1929 (Address) 4000 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL May 27 19 29

20 UNDERTAKER Joseph F. Cook

ADDRESS 1001 E. Baltimore St

Important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 46279

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 46279

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL (ST.) 7-9 (WARD)

2-FULL NAME Minnie Manns

(a) RESIDENCE NO. Port Gibson (ST.) Miss (WARD) —

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced (or) WIFE of: Wm J —

6 DATE OF BIRTH (month, day, and year): unknown.

7 AGE — Years: 5 — Months — Days — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Miss

PARENTS

10 NAME OF FATHER: Herman Goepel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Sally Bolle

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Miss

14 Informant: Friends —

(Address) JOHNS HOPKINS HOSPITAL

15 C. HARRISON JONES, M. D.

Per

Registrar

MAY 26 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 26 1929

17 I HEREBY CERTIFY, That I attended deceased from May 19 1929 to May 26 1929 that I last saw her alive on May 26 1929 and that death occurred, on the date stated above, at 8 05 A m.

The CAUSE OF DEATH* was as follows:

Brain Tumor, malignant

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 21, 1929

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) I. Ridgeway Trimble, M. D.

May 26 1929 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Port Gibson Miss — DATE OF BURIAL: 5/26/29

20 UNDERTAKER: Joseph Ahrens — ADDRESS: 221 Bway

CAUSE OF DEATH in plain terms, so that it may be properly classified. EACH STATEMENT IS VERY important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

46280

CERTIFICATE OF DEATH

4 E 46280

1-PLACE OF DEATH Jenkins Memorial Hospital REGISTERED NO.

City of BALTIMORE: (No. 1000 Caton Ave., St. 13-52 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Kerne

(a) RESIDENCE NO. 647 Falls Road St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. How long in U. S. if of foreign birth? yrs. mos. da.

Lifetime

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): October 15–1863

7 AGE Years: 65 Months: 7 Days: 9

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Balto Md

(State or country)

PARENTS

10 NAME OF FATHER Patrick Kerne

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Martin

13 BIRTHPLACE OF MOTHER (City or town)

(State or country) Ireland

14 Informant: Jenkins Mem. Hospital

(Address) Loch Raven Boulevard

15 Filed MAY 28 1929 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

May. 27 - 1929

17 I HEREBY CERTIFY, That I attended deceased from 3/25/29, 1929, to 5/24, 1929, that I last saw h alive on 5/24/29, 1929, and that death occurred, on the date stated above, at 8.15 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma Breast right
Recurrence & Metastasis to lung

(duration) 2 yrs. 11 mos. da.

CONTRIBUTORY (Secondary) General Carcinomatosis

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of Oct. 1926

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) Ercole Bonelli, M. D.

, 19 (Address) Stagg Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Mary's Cem. Govane — Date of Burial: May 27 1929

UNDERTAKER: Chas. P. Crane & Son — ADDRESS: 118 W. Mt. Royal Ave

Tion should be carefully supplied. Any doubt as to what is required should be stated. Exact statement of OCCUPATION is OF DEATH in plain terms, so that it may be properly classified. very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E46281

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46281

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 914 S. Paca ST. 21-29 (WARD)

2—FULL NAME Mary Elizabeth Le Doyen

(a) RESIDENCE NO. 914 S. Paca ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of John H. Le Doyen

6 DATE OF BIRTH (month, day, and year) Aug 12, 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	81	9	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Francis Weber

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Palmyer

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mary Kuhl
(Address) 1401 Monroe St.

15 Filed MAY 26 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 2, 1929, to May 24, 1929 that I last saw h[illegible] alive on May 24, 1929 and that death occurred, on the date stated above, at 10:00 p m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(duration) yrs. 2 mos. 24 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 6 hrs.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. Sefton Waesche M. D.

May 27, 1929 (Address) 1126 W. Cross St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Peters Cemetery DATE OF BURIAL May 29, 1929

20 UNDERTAKER J. Frederick Tom ADDRESS North Ave

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46282

CERTIFICATE OF DEATH

112

E 46282

1—PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 218 S. Caroline ST., 3rd WARD)

2—FULL NAME Nathan Ginsberg

(a) RESIDENCE NO. 218 S Caroline ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. ... mos. ... ds. How long in U. S., If foreign birth? 34 yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Bessie

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Benj Ginsberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Ida Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Samuel I. Ginsberg

(Address) 4017 Bella Ave

15 271929 C. HAMPSON JONES, M. D.

Per ..... Registrar

Important. See instructions on back of certificate.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26/29

17 I HEREBY CERTIFY, That I attended deceased from May 26th, 1929, to May 26th, 1929, that I last saw him alive on ..... , 19 ..., and that death occurred, on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Acute Indigestion

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) Some

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) Jacob L Wenner, M. D.

5/26 1929 (Address) 30 S. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Herring Run	May 27 1929
20 UNDERTAKER	ADDRESS 1127 E
Sol Levinson Bro	Balto St

Spec.—1-10-21—M&T—1500 Bks.

E 46283 E 46283

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST.) 7-9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Irene Newby

(a) RESIDENCE No. 708 S St Sparrows Point Md ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 15 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	7	1	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Eddie

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Rose Warfield

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 1929

17 I HEREBY CERTIFY, That I attended deceased from May 19, 1929, to May 25th, 1929, that I last saw her alive on May 25, 1929, and that death occurred, on the date stated above, at 9 35 P m.

The CAUSE OF DEATH* was as follows:

Acute pericarditis

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary)

~~pneumonia~~ (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Thomas Lucas, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL 5-27 1929

20 UNDERTAKER Hamilton

ADDRESS 9th

MAY 27 1929 C. HAMPSON JONES, Registrar

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46284 HEALTH DEPARTMENT—CITY OF BALTIMORE E 46284

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 536 W. Conway ST. 22-30 WARD)

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Francis Janet Davis

(a) RESIDENCE NO. 536 W. Conway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	If LESS than 1 day.....hrs. or.....min.
	44	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Alex Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Ca.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Ca.

14 Informant Maggie Wilson

(Address) 536 W Conway St

15 Filed May 27 1929 C. HAMPSON JONES, M. D. Registrar

AY 271929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 22 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 24, 19.., to May 26, 19 27.

that I last saw h.. alive on May 22, 19 27

and that death occurred, on the date stated above, at 1 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 5-27 1929

20 UNDERTAKER Samuel Easter

ADDRESS 916 Eutaw

important. See instructions on back of certificate.

Spec. 2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46285

CERTIFICATE OF DEATH

57 ✓ **E 46285**

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1220 Carroll st) (Franklin Square Hospital) (WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Kostusch

(a) RESIDENCE NO. 1220 Carroll st (Usual place of abode) ST., WARD

Length of residence in city or town where death occurred 67 yrs. 9 mos. 25 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	widow

a If married, widowed, or divorced HUSBAND of (or) WIFE of Adolph Kostusch

6 DATE OF BIRTH (month, day, and year) Aug 28 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	9	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore md

PARENTS

10 NAME OF FATHER Lotz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Vahmann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Raymond Mason (Address) 1220 Carroll st

15 Filed MAY 27 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 23 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 19 28, to May 23, 19 29, that I last saw h alive on May 22, 19 29, and that death occurred, on the date stated above, at 9 30 p. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) 1 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Cardiosclerosis

(duration) — yrs. 1 mos. 1 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) [illegible] M. D.

5/24 19 29 (Address) 517 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet Cemetery	May 27 1929
20 UNDERTAKER	ADDRESS
Jos Jacobs & Son	217 S. Pac

important. See instructions on back of certificates.

Spec. -2-29-2[illegible]—L. F. S.—500 Bks.

Ziskind

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46286

CERTIFICATE OF DEATH

E 46286

1—PLACE OF DEATH Hebrew Home for Incurables

REGISTERED NO.

CITY OF BALTIMORE: (No. 2100 E. Balto st ST., 5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Meyer Ziskind

(a) RESIDENCE NO. 908 E. Fayette St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if foreign birth? 20 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

a If married, widowed or divorced HUSBAND of (or) WIFE of Unies Ziskind

6 DATE OF BIRTH (month, day, and year) December

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Antonn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Antonn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Mrs Unies Ziskind

(Address) 908 E. Fayette st

15 Filed C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/26/29

17 I HEREBY CERTIFY, That I attended deceased from April, 1929, to May 26, 1929 that I last saw h[illegible] alive on May 26, 1929 and that death occurred, on the date stated above, at 11.30 A. m.

The CAUSE OF DEATH* was as follows:

Paralysis agitans.

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

, 19 (Address) 1810 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale — DATE OF BURIAL 5/27 19 29

20 UNDERTAKER Jack Levin — ADDRESS 1439 E. Balto st

Important. See instructions on back of certificate.

Spec.—29-28—L. F. S.—500 Bks.

Aug

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 46287

CERTIFICATE OF DEATH

E 46287

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 414 Augusta ST. 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sarah Ann

(a) RESIDENCE NO. 414 Augusta ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of: Hampton Ann

6 DATE OF BIRTH (month, day, and year): Oct 1 1854

7 AGE — Years: 74 | Months: 6 | Days: 25 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): S C

PARENTS

10 NAME OF FATHER: Moses

11 BIRTHPLACE OF FATHER (city or town) (State or country): S C

12 MAIDEN NAME OF MOTHER: Sarah Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Lancaster S C

14 Informant: Lucile McClain

(Address): 414 Augusta

15 Filed MAY 27 1929 (HAMPSON JONES, M. D.) Registrar

MAY 27 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 25-29

17 I HEREBY CERTIFY, That I attended deceased from May 23 1929 to May 25 1929.

that I last saw her alive on May 25 1929

and that death occurred, on the date stated above, at 5 30 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary): Acute Congestion Pneumonia

(duration) yrs mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jno Ford, M. D.

May 26 1929 (Address) 508 [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sumter S. C.

DATE OF BURIAL: May 28 1929

20 UNDERTAKER: Edward Bryan

ADDRESS 1681 Orleans st

Important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46288 E 46288

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH U. S Marine Hospital. REGISTERED NO.

CITY OF BALTIMORE: (No. Baltimore, Md ST., 19 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alfred Wilson

(a) RESIDENCE NO. 1518 Jefferson st ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	53—Years	Months	Days	If LESS than 1 day, ...hrs. or min.
		—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Washington Beane Somerset Co, Md

9 BIRTHPLACE (city or town) (State or country) Somerset

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) unknown
(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown
(State or country)

14 Informant Clinical records, compiled
(Address)

MAY 27 1929 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan. 25 , 1929 , to May 25 , 1929 , that I last saw h alive on May 25 , 1929 , and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis Chronic

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) hyperpiesia arterial

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical and

(Signed) Carlyn A. Porter, M. D.

, 19 (Address) U.S. Marine Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary cemetery DATE OF BURIAL May 28, 1929

20 UNDERTAKER Edward Bryan ADDRESS 1631 Orleans St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 8-29-28—L. F. S.—500 Bks.

Baushinger

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46289 — CERTIFICATE OF DEATH — **E 46289**

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. University Hospital ST. 4-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Boarshinger

(a) RESIDENCE NO. Cockeysville Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 24 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 3, 1847

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
81	6	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, bosiness, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Pennsylvania

PARENTS

10 NAME OF FATHER: Geo Baushinger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pennsylvania

12 MAIDEN NAME OF MOTHER: Sarah Seeling

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pennsylvania

14 Informant: John Baushinger Jr. Son

(Address): Phoenix Md.

15 Filed ..... 19 ..... Registrar: C. HAMPSON JONES, M. D.

No. 271929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 26 1929.

17 I HEREBY CERTIFY, That I attended deceased from May 2 . 1929 to May 26 . 1929.

that I last saw h[illegible] alive on May 26 . 1929

and that death occurred, on the date stated above, at 1 p m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis coronary disease & myocardial degeneration & Congestion Kidney & pericarditis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Heart failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) W. H. Varney, M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Jessops, Cockeysville, Md.

DATE OF BURIAL: May 29 19 29

20 UNDERTAKER: Wm C Burdofson

ADDRESS: Sparks Md.

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 46290 HEALTH DEPARTMENT—CITY OF BALTIMORE E 46290

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1733 Druid Hill Ave ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Sophia Brooks

(a) RESIDENCE NO. 1733 Druid Hill Ave ST.

(Usual place of abode) WARD

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Col 5 Single, Married, Widowed, or Divorced, (write the word) Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of John Brooks

6 DATE OF BIRTH (month, day, and year) Oct 22-1853

7 AGE 76 Years 7 Months 2 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dover, Del

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Del.

12 MAIDEN NAME OF MOTHER Ann Brookspier

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Del

14 Informant Laura Booth

(Address) 1733 Druid Hill Ave

15 Filed [illegible] C. HAMILTON JONES, M. D. Registrar

Y 271929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-24-1929

17

I HEREBY CERTIFY, That I attended deceased from 11-15-28, 19..., to 5-24-29, 19...,

that I last saw h[illegible] alive on " 19...

and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Acute Uremia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Chronic Bright's disease

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. M. Cadogan M. D.

5-24-29 (Address) 524 N. Mt Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem DATE OF BURIAL 5-27-1929

20 UNDERTAKER George T. A. Gilmore ADDRESS 1733 Druid Hill Ave

important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

E 46291

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E. 46291

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2702 Greenmount Ave (St.) (Ward) 50

2-FULL NAME Anna W Stack

(a) RESIDENCE NO. 2702 Greenmount ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank Stack

6 DATE OF BIRTH (month, day, and year): 2/14/69

7 AGE — Years: 60 — Months: 3 — Days: 11 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Jno Ritter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mr Frederick Stack

(Address) 2702 Greenmount Ave

15 Filed MAY 27 1929 19 C. HAMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 25 19 29

17 I HEREBY CERTIFY, That I attended deceased from May 5th, 1929, to May 25, 1929, that I last saw her alive on May 25, 1929, and that death occurred, on the date stated above, at 2.50 P m.

The CAUSE OF DEATH was as follows:

Cerebral Hemorrhage

Primary " 1/8/29

2nd, 3d & this 4th

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis high BP

not (duration) known mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Stroke - Paralysis

(Signed) Chas L Parker M. D.

19 (Address) 8123 N Rolling Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park

DATE OF BURIAL: 5 27 19 29

20 UNDERTAKER: H Koch

ADDRESS: 1217 E Fort Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact language of doctor TION is very important. See instructions on back of certificates.

Spec. 29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46292 — CERTIFICATE OF DEATH — E 46292

38

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO. 4-16

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alferd Smith

(a) RESIDENCE NO. 791 Sarah Ann ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Boston Mass.

PARENTS

10 NAME OF FATHER: Henry Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Mass.

12 MAIDEN NAME OF MOTHER: Emaline ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ?

14 Informant: Records of

(Address) Baltimore City Hospitals

15 Filed, ... 19 ..... Registrar

HAMPSON JONES M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 23, 1929

17 I HEREBY CERTIFY, That I attended deceased from September 21 19 27 to May 23, 19 29

that I last saw him alive on May 23, 19 29

and that death occurred, on the date stated above, at 8:30 A. m.

The CAUSE OF DEATH* was as follows:

Aneurysm of aorta

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no What test confirmed diagnosis? Physical & Lab

(Signed) Warren McPherson, M. D.

19 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	May 27, 1929
20 UNDERTAKER: Mrs. Kate R Williams	ADDRESS 3221 Schroeder St

Spec.—2-29-28—L. F. S.—500 Bks.

E 46293

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 46293

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

CITY OF BALTIMORE: (No. [illegible] ST. 1021 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Conrad A. Fisher

(a) RESIDENCE NO. 1208 E. Eager ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? —yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) May 17 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	—	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. ? Md.

PARENTS

10 NAME OF FATHER George Fisher

11 BIRTHPLACE OF FATHER (city or town) (State or country) ? Germany

12 MAIDEN NAME OF MOTHER Mary Gaes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ? Germany

14 Informant Conrad (Address) [illegible]

15 Filed [illegible], 19 [illegible] H. HAMILTON JONES, M. D. Registrar

AY 27 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1929

17 I HEREBY CERTIFY, That I attended deceased from 5-2, 1929, to 5-26, 1929, that I last saw h[illegible] alive on 5-26, 1929 and that death occurred, on the date stated above, at 2 4 m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostasis Pulmonis (Chronic)

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Course

(Signed) Marvin M. [illegible] M. D.

19 (Address) [illegible]

BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	May 28 1929
20 UNDERTAKER	ADDRESS
Henry Hoech Sons, Inc.	1501 E Eager St

important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

46294

CERTIFICATE OF DEATH.

E 46294

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hosp ST. 1724 (WARD) 46

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary A Hunter

(a) RESIDENCE NO. 1324 Druid Hill Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Cd	~~Single~~ Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Hunter

6 DATE OF BIRTH (month, day, and year) ? 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) James Hunter 1324 Druid Hill Ave

15 Filed MAY 27 1929, 19 C. HAMILTON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-26 1929

17 I HEREBY CERTIFY, That I attended deceased from 5-13, 1929, to 5-26, 1929, that I last saw her alive on 5-26, 1929, and that death occurred, on the date stated above, at 2.30 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma uteri

unknown (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Influenza (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? Date of

Was there an autopsy? Yes Clinical - Autopsy

What test confirmed diagnosis?

(Signed) W. H. Hann, M. D.

5/13, 1929 (Address) Provident Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL 5/29/1929

UNDERTAKER Mrs. Geo. H. Holland — ADDRESS 1625 Druid Hill Ave

CAUSE OF DEATH must be filled in by physician. TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46295

CERTIFICATE OF DEATH.

E 46295

129

1-PLACE OF DEATH

CITY OF BALTIMORE (No.) 2440 Mc Culloh St. 13-59 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucinda J Johnson

(a) RESIDENCE No. 2440 Mc Culloh ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Johnson

6 DATE OF BIRTH (month, day, and year) ? 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Edward Boyle

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Carolina Cubic

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant (Address) James Johnson 2440 Mc Culloh St

15 [illegible] H. HARRISON JONES, M. D. Registrar

MAY 27 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24 1929

17 I HEREBY CERTIFY, That I attended deceased from May 20 1929, to May 23 1929, that I last saw her alive on May 23 1929 and that death occurred, on the date stated above, at 4.55 a m

The CAUSE OF DEATH* was as follows:

Cardio Vascular Renal Disease

(Duration) yrs mos ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) mos. 4 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) S B Hughes M D

May 27 1929 (Address) 1413 D. Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Mt. Auburn

DATE OF BURIAL 5/27/1929

20 UNDERTAKER Mrs. Geo. H. Holland

ADDRESS 1163 Druid Hill Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46296

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 ~ E 46296

REGISTERED NO. E46296

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hospitals S. 26-48 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Bayne

(a) RESIDENCE NO. 3434 Ravenwood ave. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1868 Jan 3.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	4	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Bayne

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary McDonald

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records
(Address)

15 Filed MAY 27 1929 19 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24, 1929

17

I HEREBY CERTIFY, That I attended deceased from May 7, 1929, to May 24, 1929, that I last saw him alive on May 24, 1929, and that death occurred, on the date stated above, at 12 mid n. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No. Clinical Path.

What test confirmed diagnosis?

(Signed) Henry C. Smith, M. D.

5-25, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem.

DATE OF BURIAL May 28 1929

20 UNDERTAKER Margaret A. Flynn

ADDRESS 1422 Light St.

important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

Dungee

HEALTH DEPARTMENT—CITY OF BALTIMORE

46297

CERTIFICATE OF DEATH

90

E 46297
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1123 Myrtle Av St. 17-24 Ward)

2-FULL NAME Ethelyn Dungee

(a) RESIDENCE NO. 1123 Myrtle St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 Color or Race: Col

5 Single, Married, Widowed or Divorced. (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John B Dungee

6 DATE OF BIRTH (month, day, and year): 1860

7 AGE: Years 69 | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.: 69

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town): Va
(State or country)

PARENTS

10 NAME OF FATHER: Wm Collins

11 BIRTHPLACE OF FATHER (city or town): Va
(State or country)

12 MAIDEN NAME OF MOTHER: Unk

13 BIRTHPLACE OF MOTHER (city or town): Unk
(State or country)

14 Informant: Mary B. Lawson
(Address) 1128 Myrtle Av

15 FILED [illegible] C. HAMPSON JONES, M. D. Registrar
MAY 27 1929
Per Unk

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 25 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) T. Reynolds Leitch, M. D.
May 25/1929 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Richmond Va — DATE OF BURIAL: May 29 1929

20 UNDERTAKER: Jas. R. Bland & Son — ADDRESS: 1401 Eutaw

tion should be carefully supplied. AGE should be stated EXACTLY. Every OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 46298

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 46298

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1016 Brentwood Ave WARD 14-15)

2-FULL NAME John E. O'Neill

(a) RESIDENCE No. 1016 Brentwood Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs Cecelia A O'Neill (nee Lynch)

6 DATE OF BIRTH (month, day, and year) Dec. 10, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	5	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) Penn R.R.

(c) Name of employer Penn R.R.

9 BIRTHPLACE (city or town) (State or country) Baltimore Co. Md.

PARENTS

10 NAME OF FATHER John O'Neill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Ellen Sinnott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Mrs Cecelia A O'Neill

(Address) 1016 Brentwood Ave

MAY 27 1928 Filed HAMILTON JONES, M. D. Registrar

BY

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1928

17 I HEREBY CERTIFY, That I attended deceased from May 18 1928 to May 26 1928, that I last saw h[im] alive on May 25 1928, and that death occurred, on the date stated above, at 2.10 a.m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Asthma

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) L. McCahan, M. D.

5/27/1928 (Address) 111 W Hoffman

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL May 29, 1928

20 UNDERTAKER Elmer W. Conklin — ADDRESS 924 E Eager St.

CAUSE OF DEATH to print items, as shown in this form, is very important. See instructions on back of certificates.

Spec.—7-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46299

CERTIFICATE OF DEATH.

31 E 46299

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 522 W. Barre ST.) (77-30 WARD)

2-FULL NAME Marie Burnett

(a) **RESIDENCE NO.** 522 W. Barre ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced ~~HUSBAND OF~~ or) WIFE of Oliver Meade Burnett

6 DATE OF BIRTH (month, day, and year) 4/22/1908

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	20	8	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Warren County,
(State or country) North Carolina

PARENTS

10 NAME OF FATHER William Coleman

11 BIRTHPLACE OF FATHER (city or town) Warren
(State or country) County, N-C.

12 MAIDEN NAME OF MOTHER Nellie Read

13 BIRTHPLACE OF MOTHER (city or town) Warren
(State or country) County N C.

14 Informant Oliver M. Burnett
(Address) 522 W Barre St

15 Filed ..... 19 ..... HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24 1929

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1929, to May 24, 1929, that I last saw her alive on May 24, 1929 and that death occurred, on the date stated above, at 5:16 P. m.

The CAUSE OF DEATH* was as follows:

Cyanosis insufficiency
Pulmonary tuberculosis

(duration) ... yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Acute cardiac dilatation

(duration) ... yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Benjamin Miller M. D.

, 19 (Address) 2030 Wilkens Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Ct — DATE OF BURIAL May 27 1929

UNDERTAKER S. L. Brown & Son — ADDRESS [illegible]

CAUSE OF DEATH must be given. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46300

CERTIFICATE OF DEATH

90

E 46300

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2505 W. Lombard St., 26-42 Ward)

2-FULL NAME Marie Karl

(a) RESIDENCE NO. 4227 Bayonne ave St., 26 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) [illegible] - 1895

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	34	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife -
(b) General nature of industry, business, or establishment in which employed (or employer) 209
(c) Name of employer —

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER John Karl

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Augusta H. Butler -

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs. Ella Brate
(Address) 4227 Bayonne ave

15 Filed ..... 1929 C. HAMPSON JONES, M. D. Registrar

MAY 27 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. W. Brantz M. D.

5/24 1929 (Address) 3601 3rd Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	May 27 1929
20 UNDERTAKER Lilly & Zeller Inc	ADDRESS 40[illegible] Wayne

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 46301

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46301

REGISTERED NO. 185

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. South Baltimore General Hospit St., 4-25 Ward)

2-FULL NAME Lacey G. Collier.

(a) RESIDENCE NO. 640 N. Fayette St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. ---- mos. ---- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White.	Do not know.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) July 2, 1894

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	34	10	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Mess boy S/S Dean Emery.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Franklin, Ky.
(State or country)

PARENTS

10 NAME OF FATHER Do not knpw.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Mr. Devere.
(Address) U.S. Veterans Bureau Ft. McHenry

15 Filed MAY 27 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20, 1929 92

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull.
Accidental fall down a stairway of
S/S Dean Emery.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY
(Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Curtis Bay.

Did an operation precede death? Yes Date of May 19, 1929

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto H. Reinhardt, M. D.

5/21, 19 29 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cem. DATE OF BURIAL 5-28 19 29

20 UNDERTAKER E. B. Hart 112 E. Mad ADDRESS

tion should be carefully supplied. Age should be stated in years OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46302

CERTIFICATE OF DEATH.

91 E 46302

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 234 S. Stricker ST. 19-28 WARD)

2-FULL NAME Charles McCarthy

(a) RESIDENCE No. 234 S. Stricker ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. 4 mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) Jan. 20-1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
87	72	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Janitor

(c) Name of employer United Railways

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Jeremiah McCarthy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Sarah Ward

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Charles B. Fullenkamp (Address) 234 S Stricker

15 [illegible] HAMILTON JONES, M. D. Registrar

MAY 27 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 1929

17 I HEREBY CERTIFY, That I attended deceased from May (?) 1928 to May 25 1929

that I last saw him alive on May 24- 1929

and that death occurred, on the date stated above, at 8:45 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) several yrs. mos ds.

CONTRIBUTORY (Secondary) cardiac Dilatation

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) C. B. Buxton, M. D.

5/27, 1929 (Address) 301 E. Cross St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Cemetery DATE OF BURIAL May 28 1929

20 UNDERTAKER [illegible] ADDRESS [illegible] W Lombard St

mation should be carefully supplied. Exact statement of occupa-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.—3-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46303

REGISTERED NO. E 46303

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Homewood Apts ST. 12-50 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Estelle Edmundson Dempster

(a) RESIDENCE NO. 815 Jersey Ave. Elizabeth N.J. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. 7 mos. 22 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of J. Summerfield Dempster

6 DATE OF BIRTH (month, day, and year) Oct 4, 1890

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
38	7	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Wm W. Dunbracco

11 BIRTHPLACE OF FATHER (city or town) (State or country) Centerville Md.

12 MAIDEN NAME OF MOTHER Ella Alford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mr. J. Summerfield Dempster

(Address) 815 Jersey Ave. Elizabeth N.J.

15 Filed MAY 27 1929, HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1929

17 I HEREBY CERTIFY, That I attended deceased from November, 1927, to May 26, 1929, that I last saw h[illegible] alive on May 26, 19.., and that death occurred, on the date stated above, at 7.45 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma Left Breast

Secondaries

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Metastases liver, Brain

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Nov 17, 1921

Was there an autopsy? no

What test confirmed diagnosis? Microscope

(Signed) Geo A Stewart M. D.

May 26 1929 (Address) 904 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem.

DATE OF BURIAL May 28, 1929

20 UNDERTAKER Wm Heckrotte Sons.

ADDRESS North & Pa

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46304

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

47

E 46304

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3220 Auchentoroly ST. 13-59 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Cora Belle Klitch

(a) RESIDENCE NO. 3220 Auchentoroly Ter. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. 2 mos. 1 ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John F. Klitch

6 DATE OF BIRTH (month, day, and year) Mar 24 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John W Lyons

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Lavinia Mylander

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant John F. Klitch

(Address) 3220 Auchentoroly Ter

15 Filed DEC 27 1929, 19 HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25-29

17

I HEREBY CERTIFY, That I attended deceased from 12/8, 1928, to 5/25, 1929, that I last saw h alive on 5/25, 1929 and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis - Chronic arthritis - Cancerous Breast

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? 3228 Auchentoroly Ter.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No special test

(Signed) Jack. H. Morgan, M. D.

5-25-1929 (Address) 6-E-Bladen St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge

DATE OF BURIAL May 27 19 29

20 UNDERTAKER H. F. Eichelberger & Sons

ADDRESS Baltimore

Important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

E 46305

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001

E 46305
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1126 Calhoun St 16-22 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Latham Stewart

(a) RESIDENCE NO. 1126 Calhoun St St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 8 mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 30 1928

7 AGE Years 8 Months 7 Days 26. IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) 1126 Calhoun St
(State or country) Balto md

10 NAME OF FATHER Joseph Latham

11 BIRTHPLACE OF FATHER (City or town) Williamston
(State or country) North Carolina

12 MAIDEN NAME OF MOTHER Elizabeth Stewart

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md

14
Informant Joseph Latham
(Address) 1132 Lafayette Ave

MAY 27 1929

H. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-26- 1929

17
I HEREBY CERTIFY, That I attended deceased from 5-24-1929, to 5-26-1929,
that I last saw her alive on 5-26-1929,
and that death occurred, on the date stated above, at 12:30 P m.
The CAUSE OF DEATH* was as follows:
Bronchopneumonia

CONTRIBUTORY (Secondary) (duration) yrs. mos. 5 ds.
Exposure + Bronchitis

Unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Physical examination
(Signed) Frank A Saunders, M. D.
5-27-1929 (Address) 1029 N. Stricker St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Date of Burial May 28 1929

20 UNDERTAKER James Enright ADDRESS 1364 Mary

tion should be carefully supplied. Exact statement of OCCUPATION is OF DEATH in plain terms, so that it may be properly classified. Exact statement of CAUSE very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46306

CERTIFICATE OF DEATH

E 46306
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 309 N. Exeter St. St. 5-8 Ward)

2-FULL NAME Emma Pembrook.(O)

(a) RESIDENCE NO. 309 N. Exeter St. St., Ward
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. ---- mos. ---- ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

tion should be carefully supplied. AGE should be stated EXACTLY OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	50	----------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Charles Donald.(O)
(Address) 309 N. Exeter St.

15 Filed ....., 19 C. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:

Organic disease of the Heart.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Steinhardt, M. D.

5/22. 1929 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
PUBLIC CEMETERY

DATE OF BURIAL
19

20 UNDERTAKER
Commissioner Health.

ADDRESS
MAY 27 19

PAYABLE BY THE MORGUE

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46307

CERTIFICATE OF DEATH.

38

E 46307

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Balto City Hosp 27-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James Brown

(a) RESIDENCE NO. 193 Welcome alley St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
About	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Common

(c) Name of employer

9 BIRTHPLACE (city or town) unknown

(State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) unknown

14 Informant

(Address)

15 Filed ..... 19 ..... Registrar

THE MORGUE

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 7 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Emphysema Aorta Renal & Myocarditis General

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Chas. L. Kenton M. D.
(Coroner)

5-21-29 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death ..... yrs. ..... mos. ..... In the state ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? unknown

Former or usual residence 193 Welcome Alley

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

PUBLIC CEMETERY

UNDERTAKER

Commissioner of Health.

MAY 27 1929

Registrar

Don't fail to have this certificate properly filled out. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46308 E 46308

CERTIFICATE OF DEATH

161-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Corr 538 Linden St. 14-20 Ward)

2-FULL NAME Unknown Baby.

(a) RESIDENCE NO. Unknown St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Fem	Col	Baby

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 24/29

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
		1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) M

PARENTS

10 NAME OF FATHER M

11 BIRTHPLACE OF FATHER (city or town)
(State or country) M

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Police record
(Address)

15 Filed ..... 19 C. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceasrd came to her death
on the day stated above.
The CAUSE OF DEATH* was as follows:

Premature birth

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted? If not at place of death? Unknown
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Regular
(Signed) Fred Lee Coroner, M. D.
May 24 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
JOHNS HOPKINS HOSPITAL	May 26 1929

20 UNDERTAKER Department of Health, ADDRESS

tion should be carefully supplied. AGE should be stated EXACTLY. Prefixes, Mr., Mrs., Miss, etc., should not be used. OCCUPATION of DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46309

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001

E 46309

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 10-15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME David H. Witt

(a) RESIDENCE NO. 3210 E. Baltimore St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 5—1883

7 AGE: Years 46 | Months 4 | Days 21 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Assistant Foreman

(b) General nature of industry, business, or establishment in which employed (or employer): Plumbing supplies

(c) Name of employer: Standard Sanitary Co.

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: William E. Witt

11 BIRTHPLACE OF FATHER (city or town) (State or country): [illegible]

12 MAIDEN NAME OF MOTHER: Laura L. Brice

13 BIRTHPLACE OF MOTHER (city or town) (State or country): [illegible]

14 Informant: Patient

(Address) 3210 E. Baltimore St.

15 Filed: G. HAMPSON JONES, M. D. Registrar

MAY 27 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 26, 1929.

17 I HEREBY CERTIFY, That I attended deceased from May 24, 1929 to May 26, 1929 that I last saw him alive on May 25, 1929 and that death occurred, on the date stated above, at 3 45 A m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia, of entire left lung.

CONTRIBUTORY (Secondary) Cardiac failure (duration) yrs. mos. ds.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) W. H. Varney M. D.

. 19 (Address) University Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery DATE OF BURIAL 5/28 1929

UNDERTAKER: Chas. P. Travers & Son ADDRESS 11 W. Mt. Royal Ave

important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46310
1-PLACE OF DEATH

CERTIFICATE OF DEATH

T 185

E 46310
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of Baltimore: (No. Hotel Belvedere St., 11-15 Ward)

2-FULL NAME Leigh Miltz Marlow.

(a) RESIDENCE NO. Helena, Montana. St., Ward
(Usual place of abode)
Length of residence in city oc town where death occurred yrs. mos. 2 ds. (If non-cesident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, oc divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) May 18, 1908

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	21	0	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Helena Montana.
(State or country)

PARENTS

10 NAME OF FATHER Thomas A. Marlow.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) St. Louis Mo.

12 MAIDEN NAME OF MOTHER Louise Miltz.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Detroit Michigan

14 Informant Mrs Louise Marlow. (mother)
(Address) Helena, Montana.

15 [illegible] 19 C. HAMPSON JONES, M. D.
Registrar

MAY 27 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains deserihed above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
inquiry (Inquest, autopsy oc inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:
Fracture of the skull.
Accidental fall from an 8th floor window to the street.
(duration) yrs. mos. ds.
CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? Examination & inquiry
(Signed) Otto Fenchardt, M. D.
, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side foc additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Helena, Montana	May 31/29
20 UNDERTAKER	ADDRESS
STEWART & MOWEN COMPANY (John F. Wooden, Successor)	168 W. North

tion should be carefully supplied. Age should be stated in years, months and days. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-6-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46311 **E 46311**

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No.) Union Memorial Hospital (Street) (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No.

2-FULL NAME George Gordon Cole

(a) RESIDENCE NO. 271 Bunday Drive St. Brentwood Heights Ward Los Angeles Cal

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. ds. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced, (write the word): Divorced.

6a If married, widowed, or divorced BUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years: about 31 Months: Days: IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Solesman Phots Kinema Co

(b) General nature of industry, business, or establishment in which employed (or employer): 066

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Unknown

PARENTS

10 NAME OF FATHER G. C. Cole.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant (Address) Friend of the Dest Culver City Cal

C. HAMPSON JONES, M. D. Registrar

Per MKH

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-25 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry.) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows: Injuries from Auto Accident

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

(Signed) [signature] M. D.

(Coroner)

5/26 1927 (Address) 3632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hollywood, Cal. Date of Burial: May 27, 1929

20 UNDERTAKER: E. LeRoy Stiffler Inc. ADDRESS: 125 E. North Ave.

MAY 27 1929

tion should be carefully supplied. Answer each question in every case. Exact statement of OCCUPATION is OF DEATH in plain terms, so that it may be properly classified. very important. See instructions on back of certificate.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46312

CERTIFICATE OF DEATH

101-001

E 46312

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital S. 1-3 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lillian Esposite

(a) RESIDENCE NO. 525 S Luzerne Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Jan. 21, 1927.

7 AGE — Years: 2 Months: 4 Days: 5 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Baltimore

(State or country): Maryland

PARENTS

10 NAME OF FATHER: William Esposite

11 BIRTHPLACE OF FATHER (City or town): Baltimore

(State or country):

12 MAIDEN NAME OF MOTHER: Marie Shipley

13 BIRTHPLACE OF MOTHER (city or town): Baltimore.

(State or country):

14 Informant: Mr. William Esposite (Father)

(Address) 525 S Luzerne Ave

15 Filed MAY 27 1929 19

C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/26/29

17 I HEREBY CERTIFY, That I attended deceased from 3/31/29, 19, to 5/26/29, 19,

that I last saw her alive on 5/26/29, 19,

and that death occurred, on the date stated above, at 9:30 A.M. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary): Empyema

(duration) yrs. 1½ mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? yes Date of 4/1/29

Was there an autopsy? 5/6/29

What test confirmed diagnosis? Clinical & Operation

(Signed) J. L. Winstead, M. D.

. 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel Cemetery — Date of Burial: May 30 1929

20 UNDERTAKER: Henry Sander & Sons Inc — ADDRESS: Baltimore St & Broadway

tion should be carefully supplied. AGE should be stated EXACTLY. If unknown, approximate must be given. OCCUPATION of DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 46313

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46313

CERTIFICATE OF DEATH.

99

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Edgewood Sanitorium St. 12-50 (WARD)

2-FULL NAME Charles Herzog

(a) RESIDENCE NO. 3122 N. Calvert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Josephine Herzog

6 DATE OF BIRTH (month, day, and year) December 10. 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lawyer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Retired 8 years

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland.

PARENTS

10 NAME OF FATHER Conrad Herzog

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Deibold

13 BIRTHPLACE OF MOTHER (city or town) (State or country) France.

14 Informant Mrs. J.H. Mansbach (Address) Wentworth Apartments.

15 Filed MAY 27 1929 C. HAMPSON JONES, Registrar

By ____, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 1929

17 I HEREBY CERTIFY, That I attended deceased from July . 1928 . to May-25- . 1929 .

that I last saw h— alive on May-25 . 1929 .

and that death occurred, on the date stated above, at 3. P. m.

The CAUSE OF DEATH* was as follows:

Cirrhosis Sclerosis

Chr. Bronchitis.

(duration) 15 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocardial degeneration

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H.C. Hoen, M. D.

5-25, 1929 (Address) 5600 York Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel Cemetery — DATE OF BURIAL: May 28 1929

20 UNDERTAKER: Henry Sander & Sons Inc — ADDRESS: Baltimore St & Broadway

Y 27 1929

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46314

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46314

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) 2211 W. North Ave. ST., 8-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John H. Shinnick Jr.

(a) RESIDENCE NO. 2211 W. North Ave. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 59 yrs. 5 mos. 27 ds. How long in U. S., if foreign birth? - yrs. - mos. - ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Jane Parks

6 DATE OF BIRTH (month, day, and year): Nov. 30, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	59	5	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Superintendent

(b) General nature of industry, business, or establishment in which employed (or employer): Atlantic

(c) Name of employer: Transport Co.

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland

PARENTS

10 NAME OF FATHER: John Shinnick

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore, Maryland

12 MAIDEN NAME OF MOTHER: Frances Willis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore, Maryland

14 Informant: Mrs. Mary J. Shinnick
(Address) 2211 W. North Avenue

15 Filed MAY 27 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5-26-29.

17 I HEREBY CERTIFY, That I attended deceased from 5-23-, 1929, to 5-26, 1929.

that I last saw h. alive on 5-26, 1929

and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Embolism of brain.

CONTRIBUTORY (Secondary) Probably infarction of Lung. (duration) ... yrs. ... mos. 2 hrs. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Usual

(Signed) J. Proth, M. D.

5-26 1929 (Address) 202 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	5/28 19 29
20 UNDERTAKER: Henry U. Mears & Son	ADDRESS: 805 W. Calvert

IMPORTANT. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46315

CERTIFICATE OF DEATH.

E 46315

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) 1819 Penna ave St. W. 14-20 Ward 12-9

2-FULL NAME Virgie Williams

(a) RESIDENCE NO. 1819 Penna St. ave Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Paul Williams

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	47	2	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Va.

(State or country)

PARENTS

10 NAME OF FATHER: Geo. Burk

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Va.

12 MAIDEN NAME OF MOTHER: Matilda Gaskins

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Va.

14 Informant: Annie Fenny

(Address) 2024 Madison ave

15 Filed 7 27 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: 5/26/29

17 I HEREBY CERTIFY, That I attended deceased from April 19 1929 to May 26 1929

that I last saw h.. alive on May 25 1929

and that death occurred, on the date stated above, at 5:20 a m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) yrs. 10 mos. 7 ds.

If Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) John H. Tompkins, M. D.

19 (Address) 1127 N. Fayette ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Date of Burial

White Stone Va 5-27 1929

20 UNDERTAKER: Daniel Eaton ADDRESS 916 Eutaw

tion should be carefully supplied. Information must be given for all items. OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIO very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 46316

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31

E 46316

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Balto City Hospitals St. 18-76 Ward)

2-FULL NAME Lony Butler

(a) RESIDENCE NO. 523 Eutaw St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	Col	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
About	35			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Common
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) unknown

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) unknown

14 Informant Hospital records
(Address)

15 Filed MAY 27 1929 C. HAMPSON JONES, M. D. Registrar
By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 21 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? 103 Welcome

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Jno A Fenton, M. D.

5-22-1929 (Address) 700 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: National Cem — DATE OF BURIAL: 5-27-1929

20 UNDERTAKER: Edward Eaton — ADDRESS: Eutaw & Mt

tion should be carefully supplied. AGE should be stated EXACTLY. THIS ITEM should also be filled in. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46317

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46317

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1630 N. Broadway ST. 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Augusta W.M. Grolock

(a) RESIDENCE NO. 1630 N. Broadway ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Gustave C. Grolock

6 DATE OF BIRTH (month, day, and year) 5/17, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	0	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Frederick Discher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. Gustav C. Grolock

(Address) 1630 N. Broadway

Filed MAY 27 1929, 19

C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1929, to May 27, 1929.

that I last saw h.. alive on May 27, 1929

and that death occurred, on the date stated above, at 3 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John T. Avery, M. D.

(Address) 1603 Bolton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	5/29/29
UNDERTAKER Albert L. Hilt Jr.	ADDRESS 1505 N. CHESTER ST.

important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 46318 HEALTH DEPARTMENT—CITY OF BALTIMORE E 46318

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1329 East North Ave (ST.) (WARD) 18

2-FULL NAME Edwin Paul Ferguson

(a) RESIDENCE NO. 1329 E. North Ave ST., WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan. 1, 1929.

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
0 ~~4 mos.~~	4	26 25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Elphalete Ferguson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Philadelphia, Pa

12 MAIDEN NAME OF MOTHER Kathleen Kernan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Elphalete Ferguson
(Address) 1329 E. North Ave

15 C. HAMPSON JONES, M. D. Registrar

MAY 27 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1929

17 I HEREBY CERTIFY, That I attended deceased from May 24, 1929, to May 26, 1929, that I last saw h[illegible] alive on May 25, 1929, and that death occurred, on the date stated above, at 1.55 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) — yrs. — mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Samuel B Wolfe M. D.

5/26, 1929. (Address) 1331 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Vernon Cemetery Whitehall mausoleum DATE OF BURIAL May 28 1929

20 UNDERTAKER George F. Ruth ADDRESS 1735 Harford ave

mation should be carefully applied.
CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF
TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 46319 HEALTH DEPARTMENT—CITY OF BALTIMORE E 463[redacted]

CERTIFICATE OF DEATH.

101

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2001 Cecil av ST., 9-18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME J. Edgar Kirby.

(a) RESIDENCE No. 2001 Cecil av ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Mal

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sadie. Kirby.

6 DATE OF BIRTH (month, day, and year): Jan 7 1876

7 AGE: Years 53 Months 6 Days If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer): P. R. R.

(c) Name of employer: Penn R. R. Co

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Richard. H. Kirby.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Q. A. Co. Md.

12 MAIDEN NAME OF MOTHER: E. J. McComas.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Harford Co Md

14 Informant: E. Kirby.

(Address): 2001 Cecil av

15 Filed MAY 27 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 25, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 19, 1929, to May 25, 1929,

that I last saw him alive on May 25, 1929

and that death occurred, on the date stated above, at 7.50 a. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Edocarditis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Dwight Forsythe, M. D.

, 19 (Address) 411 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery

DATE OF BURIAL: May 28 1929

20 UNDERTAKER: Geo. - H. Ruth

ADDRESS: 1725 Harford

CAUSE OF DEATH must be given. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 46320

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46320

CERTIFICATE OF DEATH.

101-01

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 136 W. Hughes St.) (WARD) 07-21

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Williams

(a) RESIDENCE NO. 26 Hughes St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7/26/1888

7 AGE: Years 41 Months 9 Days 28 If LESS than 1 day, hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer): Long Shoreman

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Savannah Ga.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Savannah Ga.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Savannah Ga

14 Informant (Address) Office Sazuvel 106 W. Hughes St

15 Filed MAY 27 1929 . 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/24/ 1929

17 I HEREBY CERTIFY, That I attended deceased from ~~5/22~~ , 19 , to 5/24/ , 1929.

that I last saw h~~im~~ alive on 5/23/ , 1929.

and that death occurred, on the date stated above, at 8.30 A. m.

The CAUSE OF DEATH* was as follows:

Aortic Dilatation

Pulmonary Tuberculosis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical History

(Signed) [illegible], M. D.

, 19 (Address) 709 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvery

DATE OF BURIAL: May 29 1929

20 UNDERTAKER: John H. Scudieri

ADDRESS 1027 Druid Hill

CAUSE OF DEATH ... TION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46321 302 **E 46321**

CERTIFICATE OF DEATH.

REGISTERED NO. 161

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Women's Hospital ST. 27-55 WARD

2-FULL NAME Baby Boy Comenthal

(a) RESIDENCE NO. Arlington Park Apts. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 20 '29

7 AGE Years Months Days: 3

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland.

PARENTS

10 NAME OF FATHER Daniel Comenthal

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Vilma Wolf

13 BIRTHPLACE OF MOTHER (city or town) Washington (State or country) D. C.

14 Informant Mrs. Manes C. Fuld

(Address) Arlington Apts.

15 MAY 27 1929 . 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 19 29

17

I HEREBY CERTIFY, That I attended deceased from May 20 . 19 29 to May 27 . 19 29

that I last saw h alive on May 27 . 19 29

and that death occurred, on the date stated above, at 12:30 P. m.

The CAUSE OF DEATH* was as follows:

Intracranial hemorrhage following normal delivery — Symptoms lasting 4 hours.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John M. F. Bogle M. D.

. 19 (Address) 5 E W. Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Hebrew Cem. DATE OF BURIAL: 5/28/1929.

20 UNDERTAKER: Baird Sondheim ADDRESS: 41-20 W. Mt. Royal Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rks.

E 46322 HEALTH DEPARTMENT—CITY OF BALTIMORE **E 46322**

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1210 Linden Ave ST. 11-24 (WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Oscar Moore Lucas

(a) RESIDENCE NO. 1215 Linden Ave ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE~~ of: Mildred Lucas

6 DATE OF BIRTH (month, day, and year): Nov 30, 1882

7 AGE — Years: 46 — Months: 3 — Days: 27 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer): 66

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Charles Town W. Va

PARENTS

10 NAME OF FATHER: James M. Lucas

11 BIRTHPLACE OF FATHER (city or town) (State or country): Charles Town W. Va

12 MAIDEN NAME OF MOTHER: Mary Reed

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Charles Town W. Va

14 Informant (Address): Mrs Mildred Lucas 1216 Linden Ave.

15 MAY 27 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 27 1929

17 I HEREBY CERTIFY, That I attended deceased from March 23, 1929, to May 27, 1929, that I last saw h[illegible] alive on May 26, 1929, and that death occurred, on the date stated above, at 6:30 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) yrs. 2 mos 4 ds.

CONTRIBUTORY (Secondary): Gastric oesophageal Hemorrhages (duration) yrs. 1 mos — ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? no Date of ....

Was there an autopsy? no

What test confirmed diagnosis? ~~X ray~~ & Physical findings

(Signed) C. Hampson Jones M. D.

5/27, 1929 (Address) 3204 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebers Ivory W. Va — DATE OF BURIAL: May 29 1929

20 UNDERTAKER: Mary Mudafield — ADDRESS: 60 E 22nd

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT statement of CONDITION is very important. See instructions on back of certificate.

Spec.—2-20-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46323

CERTIFICATE OF DEATH

E 46323

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. University Hospital (Street) (WARD)

2—FULL NAME Mary Hutson

(a) RESIDENCE NO. Freestone Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Child.

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1927

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Freestone Md.

PARENTS

10 NAME OF FATHER Ralph Hutson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wilmington Del

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wilmington Del

14 Informant Hospital records

(Address)

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/27/29

17 I HEREBY CERTIFY, That I attended deceased from 5/26, 1929, to 5/27, 1929, that I last saw her alive on 5/27, 1929, and that death occurred, on the date stated above, at 11:30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Otitis Media,
Brain Abscess
Diffuse Bronchial Pneumonia

(duration) yrs. 5 mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Freestone Md.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Obstetric

(Signed) Wm. Lloyd Logan Jr. M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Freestone Md

DATE OF BURIAL 5/27 1929

20 UNDERTAKER Wm Cook

ADDRESS 121 St Paul St

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46324

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001

E 46324

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Steven Slowinski (Slawinski) ST. 1-3 WARD)

BALTIMORE CITY HOSPITALS

2—FULL NAME

(a) RESIDENCE NO. 2615 ~~2610~~ Fleet ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Pauline

6 DATE OF BIRTH (month, day, and year) ? 5

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
57 or 57	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) ? Poland

PARENTS

10 NAME OF FATHER Joseph Slowinski

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Poland

12 MAIDEN NAME OF MOTHER Pauline ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Poland

14 Informant Records (Address) BALTIMORE CITY HOSPITALS

15 Filed ..... 19 ..... HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-27-29

17 I HEREBY CERTIFY, That I attended deceased from 10-12, 1926, to 5-27, 1929, that I last saw him alive on 5-27, 1929 and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis ?

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Here

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Harry W. Hill, M. D.

, 19 (Address) [redacted]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	May 29 1929

20 UNDERTAKER F. W. Ozgzewski ADDRESS 1980 Edison

important. See instructions on back of certificates.

Cor.—10-10-29—A Co—100 Bks.

E 46325

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46325

CERTIFICATE OF DEATH

1-PLACE OF DEATH Pronounced Dead at

City of Baltimore: (No. Balto City Hospital St.) 3 Ward)

2-FULL NAME Leonard Smigielowski

(a) RESIDENCE NO. 307 S. Madeira St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 29 1911

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	24	1	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Collector
(b) General nature of industry, business, or establishment in which employed (or employer) Self
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Leonard Smigielowski

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland

12 MAIDEN NAME OF MOTHER Sophia Cegielski

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland

14 Informant Louis Smigielowski
(Address) 1324 Elder St

15 Filed ..... 19.. C. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquisition
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquisition
(Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Endocarditis

about
(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Embolism - Coronary Artery
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? 2307 Kerr

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Louis M Rimlow M. D.

5/27 19 29 (Address) 7008 Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Stanislaus May

DATE OF BURIAL 29 1929

20 UNDERTAKER John M Weber

ADDRESS 408 E Chester St

tion should be carefully supplied. Age should be stated in years and fractions of a year. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAY 27 1929

Paid

Spec.—2-29-28—L. F. S.—500 Bks.

3326 Fourth Ave Dr Delago

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46326 — CERTIFICATE OF DEATH — **E 46326**

1—PLACE OF DEATH

REGISTERED NO. 10-28

CITY OF BALTIMORE: (No. ST. AGNES HOSPITAL WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Grace Forrest

(a) RESIDENCE NO. 202 S. Payson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 30th 1928

7 AGE: Years 1 | Months 2 | Days 24 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work =

(b) General nature of industry, business, or establishment in which employed (or employer) =

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Wm Forrest

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Lillie Turner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Wm Forrest

(Address) 202 S Payson St

15 Filed ..... 19 ..... Per ..... Registrar

C. HAMPSON JONES, M.

1-7-1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 24/29

17 I HEREBY CERTIFY, That I attended deceased from May 22, 1929, to May 24, 1929.

that I last saw her alive on May 24, 1929

and that death occurred, on the date stated above, at 9 45 P. m.

The CAUSE OF DEATH* was as follows:

Left Cerebral Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary): Chronic Otitis Media

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? 202 S. Payson St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) D Malagó, M. D.

19 (Address) 3326 Fourth Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: WESTERN CEMETERY

DATE OF BURIAL: MAY 28/29

20 UNDERTAKER: F.B. WIPPERT

ADDRESS: 1850 W. BALTO ST

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 46327. HEALTH DEPARTMENT—CITY OF BALTIMORE E 46327.

CERTIFICATE OF DEATH

188-02

1-PLACE OF DEATH

City of Baltimore: (No.) Md Gen Hosp. St., 13-57 Ward

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emil Doll

(a) RESIDENCE NO. 3630 Malden St., W Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 Color or Race: White | 5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lelia Doll

6 DATE OF BIRTH (month, day, and year): Mar 6-1895

7 AGE: Years 34 | Months 2 | Days 19 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Helper Machinist
(b) General nature of industry, business, or establishment in which employed (or employer): Car barns
(c) Name of employer

9 BIRTHPLACE (city or town): Balto Md
(State or country)

PARENTS

10 NAME OF FATHER: Louis a Doll

11 BIRTHPLACE OF FATHER (city or town): Balto Md.
(State or country)

12 MAIDEN NAME OF MOTHER: Ida Coquet.

13 BIRTHPLACE OF MOTHER (city or town): Balto Md.
(State or country)

14 Informant: Lelia Doll
(Address) 3630 Malden

15 Filed ..... 19..... C. HAMPSON JONES, M.D. Registrar
Per .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): May 25th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Accident Machine in Car barn
Amputation of both legs.
(Duration) yrs. mos. 2 ds.
CONTRIBUTORY (Secondary) Shock
(duration) yrs. mos. hrs.

18 Where was disease contracted if not at place of death? Madison Car barn

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J B Funk, M. D.

May 27 19 29 (Address) Car barn

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery | DATE OF BURIAL: May 28 1929

20 UNDERTAKER: F.B. Kupfert. | ADDRESS: 1850 N. Bucknell

tion should be carefully supplied. ANY blanks or omissions OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 46328

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 46328

REGISTERED NO. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 439 W Lafayette Ave (ST.) 16-2-2 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. Brewer

(a) RESIDENCE No. 439 W Lafayette Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Agnes Brewer

6 DATE OF BIRTH (month, day, and year): March 7th 184

7 AGE: Years 82 Months 2 Days 19 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): =

(c) Name of employer: =

9 BIRTHPLACE (City or town) (State or country): Annapolis, Md

PARENTS

10 NAME OF FATHER: Wm Brewer

11 BIRTHPLACE OF FATHER (City or town) (State or country): Annapolis Md

12 MAIDEN NAME OF MOTHER: Mary Collins

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Annapolis Md

14 Informant: Ed. W. Brewer

(Address) 5517 Monnokat Ave

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 26 19 29

17

I HEREBY CERTIFY, That I attended deceased from Jany 1st, 19 29, to May 26, 19 29.

that I last saw him alive on May 26, 19 29,

and that death occurred, on the date stated above, at 11 30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) Life yrs. — mos — ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) — yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Hebert F Hellman, M. D.

, 19 (Address) 6 Cox Riddle Ct

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Annapolis, Md

DATE OF BURIAL: May 29th 1929

UNDERTAKER: H. D. Wyckoff

ADDRESS: 1850 W Baltimore St

CAUSE OF DEATH in plain terms, so that it may be properly TION is very important. See instructions on back of certificates.

21529

Spec.—2-29-28—L. F. S.—500 Bks.

(Protheroe)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46329

CERTIFICATE OF DEATH

90 E 46329

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 248 S. Bouldin St. WARD) 26-2

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sarah Jane Protheroe

(a) RESIDENCE NO. 248 S. Bouldin St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Protheroe

6 DATE OF BIRTH (month, day and year): August 24th 1872

7 AGE: Years 56 | Months 9 | Days 1 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): South Wales England

PARENTS

10 NAME OF FATHER: Wm Bevan

11 BIRTHPLACE OF FATHER (city or town) (State or country): Wales England

12 MAIDEN NAME OF MOTHER: Anne Lewis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Wales England

14 Informant: John Protheroe
(Address): 248 S. Bouldin St.

15 Filed ....., 19 .....
C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): May 25/29

17 I HEREBY CERTIFY, That I attended deceased from May 11th, 1929, to May 25th, 1929, that I last saw h[illegible] alive on May 25th, 1929 and that death occurred, on the date stated above, at 11.55 P m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary): Pneumonia

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Jno Young Jones M. D.

5/26/29 (Address) 401 S. 25th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Cem.

DATE OF BURIAL: May 29 1929

20 UNDERTAKER: Wm. C. Miller & Son

ADDRESS: 2334 Jefferson St.

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46330

CERTIFICATE OF DEATH

90 **E 46330**

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1131 Park Ave St. 11-24 Ward)

2-FULL NAME Jas H. Roberts

(a) RESIDENCE NO 1131 Park Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: ~~Male~~ Col

5 Single, Married, Widowed or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Alice H. Roberts

6 DATE OF BIRTH (month, day and year): ~~Oct~~ 28-1885

7 AGE: Years 43 | Months 6 | Days 27 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Chauffeur
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) Easton Md
(State or country)

PARENTS

10 NAME OF FATHER Jas Roberts

11 BIRTHPLACE OF FATHER (city) Easton
(State or country) Md

12 MAIDEN NAME OF MOTHER Caroline Jackson

13 BIRTHPLACE OF MOTHER (city) Easton Md
(State or country)

14 Informant Harry Roberts
(Address) 1550 Virginia

15 Filed ....., 19.. C. HAMPSON JONES, M. D. Registrar

Y 271929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) 2 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) May 27 '29 A. E. Finch M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Zion Cemetery — DATE OF BURIAL: 5/29/1929

20 UNDERTAKER: Eps. George E. Holland — ADDRESS: 163 Dru Hill

Fig

tion should be carefully supplied. AGE should be stated EXACTLY. OCCUPATION of DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46331 E 46331

CERTIFICATE OF DEATH.

118

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hospital (WARD) 14-20

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Walter Wallace

(a) RESIDENCE NO. 1405 E Madison ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Mid

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): 1871

7 AGE: Years 58 | Months — | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: C laborer .040

(b) General nature of industry, business, or establishment in which employed (or employer): (Steel works)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): N C

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Dr. McDonald

(Address): Provident Hospital

15 C. HAMPSON JONES, M. D. Registrar

MAY 27 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 27 1929

17

I HEREBY CERTIFY, That I attended deceased from May 20, 1929, to May 27, 1929, that I last saw h/M alive on May 27, 1929 and that death occurred, on the date stated above, at 9A m.

The CAUSE OF DEATH* was as follows:

Intestinal Obstruction

a Peritonitis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): 8 days (about)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) B Frank M. D.

May 27, 1929 (Address) Provident Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: 5/30/1929

20 UNDERTAKER: Jno. H. Holland

ADDRESS: 1651 Druid Hill Ave

CAUSE OF DEATH in plain terms, so that it may be properly coded. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46332

CERTIFICATE OF DEATH

129 E 46332

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 202 W. 27th ST. 12-5 WARD)

2—FULL NAME Mary E. Rock

(a) RESIDENCE NO. 202 W. 27th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of August Rock

6 DATE OF BIRTH (month, day, and year) May 11 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	46		14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Rohleder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mary E. Lotze

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger.

14 Informant Mr. August Rock

(Address) 202 W. 27th st

15 C. HAMPSON JONES, M. D. Registrar

MAY 28 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25-1929.

17 I HEREBY CERTIFY, That I attended deceased from December, 1926, to May 25-, 1929, that I last saw her alive on May 25-, 1929 and that death occurred, on the date stated above, at 5 P.m.

The CAUSE OF DEATH* was as follows:

Uremia - (Coma)

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis and Cardiac Hypertrophy (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) Benj. H. Hayden, M. D.

5/29/1929 (Address) 1216 N. Caroline st

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Bury	29 1929
20 UNDERTAKER	ADDRESS
Jos. J. Iderr	156 N. Eutaw

important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46333

CERTIFICATE OF DEATH

E 46333
REGISTERED NO.

1-PLACE OF DEATH Jenkins Memorial Hospital

City of BALTIMORE: (No. 1000 Eaton Ave St. 27-43 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Anna Klee

(a) RESIDENCE NO. 2913 Christopher Ave. St. Hamilton Ward

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. (If non-resident give city or town and State)

How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Randolph B. Ross

6 DATE OF BIRTH (month, day, and year): Abt. 16/1878

7 AGE — Years: ~~48~~ 50 Months: 8 Days: 11 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country): Germany

PARENTS

10 NAME OF FATHER: John Machmeyer

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Ger

12 MAIDEN NAME OF MOTHER: Anna Klem

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Ger

14 Informant: Jenkins Memorial Hospital

(Address): 1000 Eaton Avenue

Filed MAY 28 1929

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: May 27 - 1929

17 I HEREBY CERTIFY, That I attended deceased from March 1st, 1929, to May 27, 1929, that I last saw h.. alive on 5/26/29, 19..., and that death occurred, on the date stated above, at 8:00 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of both Breasts with Metastasis to both lungs.

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? 5/8/27 Left.

Did an operation precede death? Yes Date of 6/12/27 Right

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) O. H. Ernst M. D.

. 19 (Address) Hagner Hosp. Balt Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem. Date of Burial: May 30 1929

20 UNDERTAKER: J. J. Herr ADDRESS: 156 N. Luzerne

tion should be carefully supplied. AGE should be stated EXACTLY in YEARS, MONTHS and DAYS. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

E 46334 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 46334

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1523 n Rentalon ST 15-66 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Fredericka Schaefer

(Residence in Baltimore: No. 1523 n Rentalon st St.; 74 yrs. 5 mos. — da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Widow

6-DATE OF BIRTH. ~~May~~ July 8 (Month) ~~25~~ (Day), 1834 ~~1855~~ (Year)

7-AGE. 74 yrs. 10 mos. 19 da. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION:
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer).

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Lasbeck

11-BIRTHPLACE OF FATHER (State or Country). Germany

12-MAIDEN NAME OF MOTHER Unknown

13-BIRTHPLACE OF MOTHER (State or Country). Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Miss Selma Schaefer

(Address) 1523 N. Rentalon

15- MAY 30 1929 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. May (Month) 27 (Day), 1929 (Year).

17- I HEREBY CERTIFY, That I attended deceased from January 15 1929, to May 27 1929, that I saw h[illegible] alive on May 27 1929, and that death occurred, on the date stated above, at ....m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

(Duration) ....yrs. ....mos. ....da.

CONTRIBUTORY (Secondary) Old age

(Duration) ....yrs. ....mos. ....da.

(Signed) M. Stolterman M. D.

May 30 1929 (Address) 1515 N Rentalon St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. ....da. In the State ....yrs. ....mos. ....da.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. London Park Cem. DATE OF BURIAL. May 30 1929

20-UNDERTAKER For Foerders Son ADDRESS 217 S. [illegible]

CAUSE OF DEATH: Plainly state, also, contributory (secondary) causes (if any) which may have existed, and which may have induced the principal cause of death. Also the duration of each cause. Indefinite statements are insufficient. Such diseases as Cancer, Tumor, Consumption, Paralysis, Dropsy, Cholera, Convulsions, Jaundice, Hemorrhage, Gangrene, Old Age, Debility, Premature Birth, Stillborn, etc., require a more definite statement as to their origin. Name the disease causing death, rather than the mode of dying, such as Heart Failure, Asthenia, Anemia, Uremia, Coma, etc. When death is due to external causes (violence), state the accident, injury or poisoning which caused it, and the date of occurrence. Write plainly in ink. Do not use pencil. Be sure that every question is fully answered. This information is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46335

CERTIFICATE OF DEATH

38 E 46335

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS

REGISTERED NO. 21-29

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William F. Zoeller

(a) RESIDENCE NO. 1116 Sargent ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Nov. 20th 18

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Records of

(Address): Baltimore City Hospitals

15 Date: ..... 19 ..... C. HAMILTON JONES, M. D. Registrar

MAY 28 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 27, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 23, 1929, to May 27, 1929, that I last saw him alive on May 27, 1929 and that death occurred, on the date stated above, at 4:55 A. m.

The CAUSE OF DEATH was as follows:*

Tabo-Paresis — Syphilis

Unknown (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Syphilis

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) Harvey [illegible] Cushing, M. D.

19 (Address) Baltimore City Hosps.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	May 29 1929
20 UNDERTAKER: John J. Bowar & Son	ADDRESS: 901 Lafayette Ave.

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46336

1-PLACE OF DEATH

City of Baltimore: (No. 2124 E. Federal St St., 8-16 Ward)

2-FULL NAME Elizabeth J. Kramer

(a) RESIDENCE NO. 2124 E. Federal St St., Ward
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

185

E 46336

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Charles W. Kramer

6 DATE OF BIRTH (month, day, and year) Oct 5/1879

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	49	7	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) At home
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Michael Buser

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Annie Sachs bradel

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto., Md.

14 Informant Charles W. Kramer
(Address) 2124 E. Federal St

19 C. THAMPSON JONES, M.D.
Physician or Coroner

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry. (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Intracranial Hemorrhage
Frac Skull- Accidently fell
down stairs at residence
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Cowen, M. D.

19 (Address) 308 E. North Ave 5/27/29

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	May 29 1929
20 UNDERTAKER	ADDRESS
Henry Hirsch & Son Inc	1301 E Cas Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHRASING of OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MAY 28 1929

Reg'r

Spec.—2-29-28—L. F. S.—500 Bks.

46337

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 46337

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2021 Jefferson ST. 6-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lillian Hall

(a) RESIDENCE NO. 2021 Jefferson ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 41 yrs. 8 mos. 18 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of John S Hall

6 DATE OF BIRTH (month, day, and year) Sept 8th 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	8	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER William Pistel

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Jennie Bass

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant John S Hall

(Address) 2021 Jefferson st

15 Filed MAY 28 1929 HAMILTON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 24, 1929, to May 26, 1929, that I last saw her alive on May 26, 1929, and that death occurred, on the date stated above, at 8.10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Urinalysis

(Signed) Joseph Pokorny, M. D.

, 19 (Address) 220 E Madison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	May 29th 1929
20 UNDERTAKER	ADDRESS
George Schilling & Sons	1126 E Monument st

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46338

CERTIFICATE OF DEATH

90

E 46338

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 5106 Belair Road ST. 27-41 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Caroline G. WECK

(a) RESIDENCE NO. 5106 Belair Road ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Casper H. Weck

6 DATE OF BIRTH (month, day, and year) August 15, 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	9	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) NONE

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Co.
(State or country) Maryland

PARENTS

10 NAME OF FATHER Ernest Treuth

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Hoop

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mr. Harry Weck
(Address) 5106 Belair Road

15 Filed MAY 28 1929 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25th, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 15, 1928, to May 25, 1929 that I last saw h[illegible] alive on May 25th, 1929 and that death occurred, on the date stated above, at 8:35 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. S. Harding, M. D.

, 19 (Address) 4810 Belair Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	May 28, 1929
UNDERTAKER Frederick Lorsalmo Sons	ADDRESS Fullerton, Md.

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46339

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 46339

CERTIFICATE OF DEATH

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 1-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank Trachta

(a) RESIDENCE NO. 1012 S. Robinson ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if foreign birth? 41 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Trachta

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	37			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Bill Trachta

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Elex ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Records of

(Address) Baltimore City Hospitals

15 [illegible] HAMPSON JONES M. D. (Registrar)

MAY 28 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 21, 19 29 to May 26, 19 29.

that I last saw him alive on May 26, 19 29

and that death occurred, on the date stated above, at 5:45 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) Empyema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Thoracentesis Date of 5-24-29

Was there an autopsy? no

What test confirmed diagnosis? X-Ray & Laboratory

(Signed) [illegible] M. D.

, 19 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	May 29 1929
20 UNDERTAKER	ADDRESS
Knox Brack Son	1906 Eden

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46340

CERTIFICATE OF DEATH

E 46340
REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
City of Baltimore: (No. City Hospital St., 1-3 Ward)

2-FULL NAME John Tombs

(a) RESIDENCE NO. 2525 Eastern St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary Tombs

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	63			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Steel Mills
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Austria

PARENTS

10 NAME OF FATHER Frank Tombs

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Austria

12 MAIDEN NAME OF MOTHER Mandovan

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Austria

14 Informant Mary Tombs
(Address) 2525 Eastern

15 [illegible] 1929 HARRISON JONES, M. D.
Registrar

MAY 28 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:
Motor Cycle Acc
Multiple Fracture
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Shock
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 2525 Eastern
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?
May 26 1929
(Signed) G. E. Wadell, M. D.
(Address) 143 N. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	May 29 1929

20 UNDERTAKER Hunt & Brockden 1908 E. Baltimore
ADDRESS

tion should be carefully supplied. AGE should be stated EXACTLY. PLACE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

46341

CERTIFICATE OF DEATH

E 46341

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Kernan Hotel St. 11-25 Ward)

2-FULL NAME Otto Peterson

(a) RESIDENCE U. S. Naval Home Phila Pa. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Widower

5a If married, widnwed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) —

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	79			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired U. S. Navy
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Sweden
(State or country)

PARENTS

10 NAME OF FATHER Sven Peterson

11 BIRTHPLACE OF FATHER (city or town) Sweden
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Mrs. J. Peterson
(Address)

Filed ... 19 ... C. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. — mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. C. Leith, M. D.
May 25 1929 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Phila. Penna	May 29 1929
20 UNDERTAKER Chas. O. Mitchell Funeral Home	ADDRESS

AY 261229

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S CERTIFICATE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 25624
E 46342

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

E 46342
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. 12-51 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arthur Buchanan

(a) RESIDENCE NO. 314 W. 28th St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Often mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): April-26-1929

7 AGE — Years: 1 — Months: ~~5 mos~~ — Days: — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Arthur Buchanan

11 BIRTHPLACE OF FATHER (city or town) (State or country): S Car

12 MAIDEN NAME OF MOTHER: Ivy Gebhard

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N Car

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

Filed MAY 29 1929 C. HAMPSON JONES, M. D. Registrar

By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 26 1929

17

I HEREBY CERTIFY, That I attended deceased from May 23 1929, to May 26 1929, that I last saw him alive on May 26 1929, and that death occurred, on the date stated above, at 7.35 P m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) yrs mos 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No. Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) L. C. Goodwin M. D.

5/27, 1929 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem DATE OF BURIAL: May 28 29

20 UNDERTAKER: Samuel Hawsley ADDRESS 538 N Biddle

MAY 29 1929

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46343

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46343

CERTIFICATE OF DEATH

49

1—PLACE OF DEATH

REGISTERED NO. 13552

CITY OF BALTIMORE: (No.) 3621 (ST.) Roland Ave (WARD) 13

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Natalie Elizabeth Belt

(a) RESIDENCE NO. 3621 (ST.) Roland Ave (WARD) 13

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of John R. Belt

6 DATE OF BIRTH (month, day, and year) Jan. 28-1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	74	3	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Worcester Co. Md.

PARENTS

10 NAME OF FATHER Peter Timbrough

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sibbie A. Morris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs John Belt

(Address) 618 E. 36th St.

15 Filed MAY 28 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25-1929.

17 I HEREBY CERTIFY, That I attended deceased from March 20, 1929, to May 25, 1929.

that I last saw h alive on May 24, 1929

and that death occurred, on the date stated above, at 9.30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma right axilla and general Carcinosis

(duration) 2 yrs. 3 mos. — ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. W. Richardson, M. D.

May 28, 1929 (Address) 550 W. 36th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's Hampden	May 28 1929
20 UNDERTAKER Horace A. Burgee	ADDRESS 3311 Hollins Road

Spec.—1-12-23—M&T—500 Blks.

E 46344 HEALTH DEPARTMENT—CITY OF BALTIMORE E 46344

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3023 Westwood Avenue WARD 46 65 29

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Bowers of

(a) RESIDENCE No. 3023 Westwood Avenue WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 87 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James W. Bowers

6 DATE OF BIRTH (month, day, and year) May 6 1842

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	87	—	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Alexander Scott

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Sarah Jane Preston

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Rebecca Dunbar

(Address) 3017 Westwood Ave

MAY 24 1929 JAMES R. JONES, M. D. 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26th 1929

17 I HEREBY CERTIFY, That I attended deceased from January 15th 1929, to May 26th 1929, that I last saw h alive on May 26th 1929, and that death occurred, on the date stated above, at 5.15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 3 yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) — yrs. 9 mos. 8 ds.

18 Where was disease contracted if not at place of death? Home of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Microscopic

(Signed) Wm. T. Sullivan, M. D.

5-27 1929 (Address) 1701 W. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	May 28, 1929
20 UNDERTAKER	ADDRESS
E. LeRoy Stifflen Inc.	125 E. North Ave.

CAUSE OF DEATH to be plain terms, so that it may be properly TION is very important. See instructions on back of certificates.

HARRISON BROS. & CO. BALTO.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46345

E 46345

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 1238 W. Lanvale St. 16-23 (Ward)

2-FULL NAME Baby Devalient Burrell

(a) RESIDENCE NO. 1238 W Lanvale St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. 4 mos. 25 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of No

6 DATE OF BIRTH (month, day, and year) Dec 30-1914

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	14	4	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Sidney Burrell

11 BIRTHPLACE OF FATHER (city or town) Va

(State or country)

12 MAIDEN NAME OF MOTHER Sophia Wells

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant Sidney Burrell

(Address) 1238 W Lanvale

15 Filed MAY 28 1929 C. HAMILTON JONES, Registrar

By [illegible]

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) May 25 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Measles.

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) F. C. Leuth, M. D.

May 25 1929 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Auburn	May 28 1929
20 UNDERTAKER	ADDRESS
Joseph A Lively	1211 Mount St

tion should be carefully supplied. AGE should be stated EXACTLY. If infant, NAME OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46346

CERTIFICATE OF DEATH.

E 46346

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Franklin Sq. Hosp (St.) (Ward) 7-21

2-FULL NAME Baby girl Bull

(a) RESIDENCE NO. Parkton Md ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: fem.

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): 6 month premature

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years — Months — Days — If LESS than 1 day, 6 hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Arthur M. Bull

11 BIRTHPLACE OF FATHER (city or town) (State or country) Parkton Md.

12 MAIDEN NAME OF MOTHER Gerber

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cockeysville Md.

14 Informant Father
(Address)

15 MAY 28 1929 C. HAYDEN JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 1929.

17 I HEREBY CERTIFY, That I attended deceased from May 25, 1929, to May 25, 1929,

that I last saw her alive on May 25, 1929,

and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Prematurity
Therapeutic abortion
Pyelitis & Endocarditis

(duration) ..... yrs ..... mos ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Arthur Rattenni M. D.

5/26 1929 (Address) Franklin Sq Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

MAY 27 192

UNIVERSITY OF MARYLAND

IMPORTANT—Should be filled out by person in charge of CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 46347

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 46347

101-002

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 14-28 WARD)

2-FULL NAME Yetta Block

(a) RESIDENCE No. 238 S Calhoun ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) ~~May 28-1908~~ Dec 2

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	20	5	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work office work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Adolph Block

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Molly Cohen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Date MAY 28 1929 H. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28 1929

17 I HEREBY CERTIFY, That I attended deceased from May 23, 1929, to May 28, 1929, that I last saw h.. alive on May 28, 1929, and that death occurred, on the date stated above, at 5 50 a m.

The CAUSE OF DEATH* was as follows:

1 Arteriosclerosis

2 Intestinal Fistula

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) George G Finney, M. D.

5/28 1929 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Nehrer Rosedale — DATE OF BURIAL 5/28 1929

20 UNDERTAKER Jack Levis 1439 — ADDRESS Fells

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 25175
E 46348

CERTIFICATE OF DEATH.

E 46348
REGISTERED NO.

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 7-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Gautier

(a) RESIDENCE NO. Triton W Va ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 19 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

Exact statement of OCCUPA-
TION is very important. See instructions on back of certificates.
CAUSE OF DEATH in plain terms, so that it may be properly classified.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M.	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) cant

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Petty
(State or country) W. Va

PARENTS

10 NAME OF FATHER J. R.

11 BIRTHPLACE OF FATHER (city or town) W Va
(State or country)

12 MAIDEN NAME OF MOTHER Mary Goodson

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed MAY 29 1929 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28 1929

17 I HEREBY CERTIFY, That I attended deceased from May 9, 1929, to May 28, 1929, that I last saw him alive on May 24, 1929, and that death occurred, on the date stated above, at 12 50 A m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) ..... yrs. ..... mos. 4 ds.

Pentonitis

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? yes Date of 5 24 29

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Wm Algeo, M. D.

19 (Address) J. H. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore, Md

DATE OF BURIAL 5/28/29

20 UNDERTAKER Joseph Lahens

ADDRESS 221 Saratoga

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

59-003

E 46349

CERTIFICATE OF DEATH

E 46349
REGISTERED NO.

1—PLACE OF DEATH Union Memorial Hosp

CITY OF BALTIMORE: (No. 33d & Calvert ST. 12-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Richard Strack

(a) RESIDENCE NO. 307 Lorraine Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 7 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	0	1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Edward Strack

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Emma Abbey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs Strack

(Address) 307 Lorraine Ave

15 Filed MAY 28 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/27/29

17 I HEREBY CERTIFY, That I attended deceased from May 25, 1929, to May 27, 1929, that I last saw h[illegible] alive on May 27, 1929 and that death occurred, on the date stated above, at 12 45 A. m.

The CAUSE OF DEATH* was as follows:

Congenital hypertrophic pyloric Stenosis

(duration) yrs. 1 mos. 20 ds.

CONTRIBUTORY (Secondary) Malnutrition

(duration) yrs. 1 mos. 20 ds.

18 Where was disease contracted if not at place of death? Congenital

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical findings

(Signed) Wallace K. Swartzwelder, M. D.

, 19 (Address) 33d & Calvert sts (Hospital)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem DATE OF BURIAL May 29, 1929

20 UNDERTAKER A. Howard Evans ADDRESS 385 Fordham

Important. See instructions on back of certificate

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46350 E 46350

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 677 Washington Blvd ST. 24 WARD)

REGISTERED NO. 16708

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carl A. Presti

(a) RESIDENCE No 677 Washington Blvd ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? 2 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced (write the word) Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6 DATE OF BIRTH (month, day, and year) May 26-29

7 AGE Years Months Days 1 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Stephen Presti

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)

12 MAIDEN NAME OF MOTHER Pauline B. Anden

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant Mrs. Presti (Address) 677 Washington Blvd

15 Filed MAY 29 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1929

17 I HEREBY CERTIFY, That I attended deceased from May 26, 1929, to May 27, 1929, that I last saw h[illegible] alive on May 27, 1929, and that death occurred, on the date stated above, at 9 P.M.

The CAUSE OF DEATH* was as follows: Meningitis due to Prematurity

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Malformed Contracted Palate (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jos. L. Valentine M. D.

1929 (Address) 1X So Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Jerome's. DATE OF BURIAL 5/29 1929

20 UNDERTAKER J J Fahey Sons ADDRESS 1318 Light

mation should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—2-29-28—L. F. S.—500 lbs.

John Mayfield

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46351

CERTIFICATE OF DEATH

31

E 46351

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 514 Brune ST. 20-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Mayfield

(a) RESIDENCE NO. 514 Brune ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 17, 1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	27	9	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Charlottesville, Va

PARENTS

10 NAME OF FATHER John Mayfield

11 BIRTHPLACE OF FATHER (city or town) (State or country) Charlottesville Va

12 MAIDEN NAME OF MOTHER Amanda Black

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Charlottesville Va

14 Informant Malinda Parker

(Address) 514 Brune St

15 Filed ..., 19.. HAMPTON JONES, M. D. Registrar

MAY 28 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-24-1929.

17 I HEREBY CERTIFY, That I attended deceased from 4-27-27, 19.., to 5-24-29, 19..,

that I last saw h[illegible] alive on ..., 19..

and that death occurred, on the date stated above, at 6.30 a, m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) T. A. Landon, M. D.

5-24-29 (Address) 534 N. Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	May 28, 1929
20 UNDERTAKER Mrs Kate R. Williams	ADDRESS 3227 Schroeder St

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46352

CERTIFICATE OF DEATH

E 46352

1—PLACE OF DEATH

REGISTERED NO. 96-48

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 3027 Shannon Drive ST. WARD)

2—FULL NAME Wm. H. B. Haynes

(a) RESIDENCE NO. 3027 Shannon Drive ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced (or) WIFE of: Frances Haynes

6 DATE OF BIRTH (month, day, and year): Sept 19/1870

7 AGE: Years 58 | Months 8 | Days 7 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer): M. C. Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Geo. Haynes

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Ella Bowers

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Mrs. Frances Haynes

(Address) 3027 Shannon Drive

15 [illegible] 19 [illegible]

Y 28 1929 W. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 26/29

17 I HEREBY CERTIFY, That I attended deceased from Mch 24, 1929 to May 26, 1929

that I last saw him alive on May 25, 1929

and that death occurred, on the date stated above, at 3 A.M. m.

The CAUSE OF DEATH* was as follows:

Chron Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) [signature] , M. D.

5/27/29 (Address) 6 E. Mt. Vernon Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cem

DATE OF BURIAL: May 29, 1929

20 UNDERTAKER: Philip Herwig

ADDRESS 2016 Eutaw St

Important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46353

CERTIFICATE OF DEATH.

129

E 46353

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1413 Jackson ST. 14-33 (WARD)

2-FULL NAME Peter Campbell

(a) RESIDENCE NO. 1413 Jackson ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nellie Campbell

6 DATE OF BIRTH (month, day, and year) April 4 1869

7 AGE	Years	Months	Days 25	If LESS than 1 day, hrs. or min.
	60	1	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hostler B&O R.R.

(b) General nature of industry, business, or establishment in which employed (or employer) 03

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER Pat. Campbell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Nellie Campbell

(Address) 1413 Jackson St.

MAY 23 1929

H. HARRISON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5.26.29.

17

I HEREBY CERTIFY, That I attended deceased from 10.17.28 19 to 5.26.29. 19

that I last saw h in alive on 5.25.29. 19

and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 8 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical-Clinical Urine.

(Signed) Philip B. Fowler M. D.

5.27.29 (Address) 1432 William St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL May 27 1929

UNDERTAKER Margaret J. Flynn

ADDRESS 1422 Eight St.

CAUSE OF DEATH to be plainly written, without abbreviations. TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 46354

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001

E 46354

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 724 Hanover St. St. (Ward) 22-30

2-FULL NAME Lester Williams.(C)

(a) RESIDENCE NO. 724 Hanover St. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 mos 22 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) March 5, 1929

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	0	2	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER George Williams.(C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Norfolk, Va.

12 MAIDEN NAME OF MOTHER Ethel Wilson.(C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Norfolk. Va.

14 Informant Ethel Williams.(C) mother.
(Address) 724 Hanover St.

MAY 28 1929

19 [illegible] C. H. [illegible] JONES, M. D.
Registrar

Per [illegible]

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia.
unknown.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto H. Leimandt, M. D.

5/28, 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary Cemty

DATE OF BURIAL 5/30 1929

20 UNDERTAKER Walter B. Griggs

ADDRESS 539 W. Baltimore St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46355 — CERTIFICATE OF DEATH — E 46355

164

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2530 W Balto ST. 6-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sallie A Burch

(a) RESIDENCE NO. 2530 W Baltimore St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm A Burch

6 DATE OF BIRTH (month, day, and year) Mch 27 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	2	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Robt Hanson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Martha Hanson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Miss Mattie Burch

(Address) 2530 W Balto St

15 Filed [illegible] C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27-29

17

I HEREBY CERTIFY, That I attended deceased from May 1st, 1929, to May 27, 1929, that I last saw h[illegible] alive on May 27, 1929 and that death occurred, on the date stated above, at 6.20 P. m.

The CAUSE OF DEATH* was as follows:

Senile asthenia & Debility of Advanced age. No Specific disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) M. F. Smith, M. D.

May 28 1929 (Address) Arnold Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem — DATE OF BURIAL: 6/31 1929

20 UNDERTAKER: Geo A Fahy Fulton Fayette — ADDRESS

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 46356

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46356

CERTIFICATE OF DEATH.

X 159

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) JOHNS HOPKINS HOSPITAL ST. 9-9 WARD)

2-FULL NAME Joan Weiss

(a) RESIDENCE NO. 1130 Carol St ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? Brooklyn-NY (If non-resident give city or town and State) ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fe

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 24/29

7 AGE — Years — Months 2 — Days — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... ditto

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... (State or country) NY

PARENTS

10 NAME OF FATHER Benjamin

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) NY

12 MAIDEN NAME OF MOTHER Mary Hollander

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) NY

14 Informant Resident
(Address) JOHNS HOPKINS HOSPITAL

15 MAY 28 1929 C. HAMPSON JONES, M. D. Registrar

BY ..... Asst

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/28 1929

17 I HEREBY CERTIFY, That I attended deceased from 5-22, 1929, to 5-28, 1929, that I last saw her alive on 5-28, 1929, and that death occurred, on the date stated above, at 1:10 P.M.

The CAUSE OF DEATH* was as follows:

Hydrocephalus

Autopsy

(duration) yrs. 8 weeks mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of May 23, 1929

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) I R Lundsk, M. D.

May 28, 1929 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Brooklyn New York — DATE OF BURIAL: May 28 1929

UNDERTAKER: S Lennon Bro — ADDRESS 1127 E Baltimore St

mation should be carefully supplied. Exact statement of CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46357

CERTIFICATE OF DEATH

31 E 46357

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST., 8-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Clarence Johnson

(a) RESIDENCE NO. 1706 Llewellyn ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Separated

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Andrew Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Lucy Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records

(Address)

15 Filed MAY 28 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25, 1929

17

I HEREBY CERTIFY, That I attended deceased from April 27, 1929, to May 25, 1929, that I last saw h im alive on May 25, 1929 and that death occurred, on the date stated above, at 3.15 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical and lab.

(Signed) Henry C. Smith M. D.

5-25-1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
National Cemetery	May 29 1929
20 UNDERTAKER J. Lennon Bro	ADDRESS 1127 E Balto St

IMPORTANT. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46358

CERTIFICATE OF DEATH.

90

E 46358

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) Home for Incurables (St.) (Ward)

2-FULL NAME Robert Carter

(a) RESIDENCE NO. 1214 Cold Spring Lane S. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. da. How long in U. S., if of foreign birth? yrs. mos. da.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Ada Carter

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer) American Railway

(c) Name of employer Express Co Va

9 BIRTHPLACE (city or town)

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Medford Carter

(Address) 1214 Cold Spring Lane

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D., Registrar.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/28 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Paralysis

Diseased Heart (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) (duration) ..... yrs. ..... mos. ..... ds.

(Signed) John Morrison M. D.

(Address) 1632 Orleans 5/28 1929

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Marys Hampden — Date of Burial May 31 1929

20 UNDERTAKER Chenowith Bros. — ADDRESS 1615 Eutaw

Don should be carefully supplied. AGE should be stated. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Y 101929

Spec. 2-29-28—L. F. S.—500 Bks.

E 46359

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001

E 46359

1—PLACE OF DEATH

REGISTERED NO. 12-46

CITY OF BALTIMORE: (No. 3415 University Place) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Fannie Taylor Stone

(a) RESIDENCE NO. 3415 University Place ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 10 mos. 16 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	widow

a If married, widowed, or divorced HUSBAND of (or) WIFE of James H Stone

6 DATE OF BIRTH (month, day, and year) July 11 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	10	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Robert Rusk

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Price

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant Elizabeth Stone Buckingham

(Address) 3415 University Place

15 Filed 19

C. HAMPSON JONES, M. D.
Registrar

Y 28 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27. 29

17 I HEREBY CERTIFY, That I attended deceased from Apr 20, 1929, to May 27, 1929, that I last saw h[illegible] alive on May 27, 1929 and that death occurred, on the date stated above, at 8 30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

5 weeks.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [redacted], M. D.

. 19 (Address) [redacted]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL May 29 1929

20 UNDERTAKER Chas. J. Black

ADDRESS 742 W. North ave

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46360
1-PLACE OF DEATH

CERTIFICATE OF DEATH

31

E 46360
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of Baltimore: (No. 851 Carroll St. 21-29 Ward)

2-FULL NAME Mary E. Butler

(a) RESIDENCE NO. 851 Carroll St., Ward
(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Harry Butler

6 DATE OF BIRTH (month, day, and year) Apr 1, 1891

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	38	1	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work W. W. 27
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER Fillmore Todd

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Jennie Purston

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Harry Butler
(Address) 851 Carroll

MAY 29 1929 19 C. HAMILTON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.
The CAUSE OF DEATH* was as follows:
Pulmonary Hemorrhage
(Tuberculosis)

(duration) yrs. 2 mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. H. Brooke, M. D.
5-27, 1929 (Address) 3601 3rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — DATE OF BURIAL May 30 1929

20 UNDERTAKER W. M. Coop — ADDRESS 1317 Light St

tion should be carefully supplied. AGE should be stated EXACTLY. PROFESSION OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

Bowdle.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46361

CERTIFICATE OF DEATH

E 46361

1—PLACE OF DEATH Union memorial Hospital 33rd & Calvert Sts

REGISTERED NO. 12-49

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ada C. Bowdle.

(a) RESIDENCE NO. Pikesville Md ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan. 9, 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	50	4	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Dr W. J. Bowdle.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ada Carroll.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital records

(Address)

15 Filed ..... 19..... C. HAMPSON JONES, M. D. Registrar

MAY 29 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28, 1929

17 I HEREBY CERTIFY, That I attended deceased from February 18 1929, to May 28, 1929.

that I last saw h.. alive on May 28, 1929

and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of ovary with generalized abdominal carcinomatosis

(duration) 1 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Washington D. C.

Did an operation precede death? yes. Date of Feb 27, 1929

Was there an autopsy? no.

What test confirmed diagnosis? Path. report of Operation

(Signed) Frances M. Fleck, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Congressional Cem

DATE OF BURIAL 5-31 1929

20 UNDERTAKER Washington D.C. Henry W. Jenkins & Sons Co

ADDRESS Orchard & McCulloh

important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

225319 **E 46362**

CERTIFICATE OF DEATH.

100-00 **E 46362**

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. 14-20 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Kenneth Garner

(a) RESIDENCE NO. 1425 Madison Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: B.

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 5, 1929

7 AGE: Years — Months — Days 21 20 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — (0)

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER James

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Nettie Randall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 1929

17 I HEREBY CERTIFY, That I attended deceased from May 14, 1929, to May 25, 1929, that I last saw h im alive on May 25, 1929, and that death occurred, on the date stated above, at 8 15 P m.

The CAUSE OF DEATH* was as follows:

Inhalation pneumonia

Bronch: pneumonia

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Prematurity

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Phys. exam.

(Signed) [illegible], M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

14 Informant (Address) Records JOHNS HOPKINS HOSPITAL

15 Filed [illegible] 19 C. HAMPSON JONES, M. D. Registrar

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health.

ADDRESS MAY 28 1929

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 46363

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46363

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1123 Penna. ave St. 17-25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas Jones

(a) RESIDENCE NO. 1123 Penna. ave St. Ward 9a

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. 4 ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Negro

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Annie Jones

6 DATE OF BIRTH (month, day, and year): Nov 23 1861

7 AGE: 67 Years 68 Months 6 Days 5

IF LESS than 1 day ....hrs. or ....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) Southampton (State or country) Va

PARENTS

10 NAME OF FATHER: Joseph Jones

11 BIRTHPLACE OF FATHER (City or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER:

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Elizabeth Hill

(Address) 1123 Penna. ave

C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1929: May 28, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 28, 1929, to May 28, 1929, that I last saw him alive on May 25, 1929, and that death occurred, on the date stated above, at 2:00 P. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis and organic heart disease

(duration) two yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death? In Virginia

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Mechanical Engorgement

(Signed) Wm H. Hill, M. D.

May 28 1929 (Address) 928 Penna. ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cemetery Laurel Md. Date of Burial: May 29 1929

20 UNDERTAKER: John H. Owens ADDRESS 538 Dodd St

MAY 29 1929

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46364

CERTIFICATE OF DEATH

100-201

E 46364

1—PLACE OF DEATH Balto City Hospls. REGISTERED NO.

CITY OF BALTIMORE: (No. Balto Md ST., 1-3 WARD)

2—FULL NAME John Lang (Lyons) (LANG)

(a) RESIDENCE NO. 2335 Eastern Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 15th 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
~~57~~	57	2	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work do

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wesley Lang Unknown

11 BIRTHPLACE OF FATHER (city or town) Germany (State or country) Unknown

12 MAIDEN NAME OF MOTHER Catt. Unknown

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country) Unknown

14 Informant Balto City Hospls.

(Address) Balto Md

15 Filed ... 19 HAMPSON JONES, M. D. Registrar

CLEARED

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-27-29

17

I HEREBY CERTIFY, That I attended deceased from 5-15-, 1929, to 5-27-, 1929

that I last saw him alive on 5-27-, 1929

and that death occurred, on the date stated above, at 10.45 P. m.

The CAUSE OF DEATH* was as follows:

Terminal Bronchio Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchus & Cerebral arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) Hamp H Jones M. D.

5/28, 1929 (Address) Balto City Hospls

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	May 29th 1929
20 UNDERTAKER	ADDRESS
Lilly & Sons Inc	4030 Wash Ave

important. See instructions on back of certificates.

Spec.—7-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46365

E 46365

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 101

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 623 N. Decker Ave ST., 7 WARD) 711

2—FULL NAME Genevieve Marie Winterling

(a) RESIDENCE NO. 623 N. Decker Ave ST., 7 WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. 5 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 22nd 1928

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		8	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Albert E. Winterling

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Marie T. Stuck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Albert E. Winterling

(Address) 623 N. Decker Ave

15 Date received MAY 29 1929, 19 Registrar. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27th 1929

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1929, to May 27, 1929, that I last saw her alive on May 27, 1929, and that death occurred, on the date stated above, at 7:[illegible] P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Findings

(Signed) Vincent B. Dorka, M. D.

, 19 (Address) 845 W. Fayette St. Balto Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cemetery	May 30th 1929
20 UNDERTAKER Lilly & Gillen Inc	ADDRESS 402 N. Howard St

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46366

E 46366

CERTIFICATE OF DEATH

24

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1078 S. Dean ST.) (26-37 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Evelyn A. Horney

(a) RESIDENCE NO. 1707 S. Dean ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6 DATE OF BIRTH (month, day, and year): Mar 17-1928

7 AGE — Years: — Months: 6 — Days: 11 — If LESS than 1 day, hrs or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Thos E Horney

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Bertha M Brehm

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Thos E Horney

(Address): 707 S Dean St

15 [illegible] 19 [illegible]

C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 28. 1929.

17 I HEREBY CERTIFY, That I attended deceased from May 20 19 29 to May 28 19 29

that I last saw her alive on May 26, 1929 19

and that death occurred, on the date stated above, at 11 [illegible] m.

The CAUSE OF DEATH* was as follows: May 28, 1929

Pneumonia, Lobular

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Otitis media, pharyng. Tu - cured Meningococcus meningitis

(duration) yrs. mos. 26 ds.

18 Where was disease contracted if not at place of death? In hospital (?)

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) D Morgan Pei Cam M. D.

19 (Address) John Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Carmel

DATE OF BURIAL: May 30 19 29

20 UNDERTAKER: John Ellis

ADDRESS: 2008 Orleans

important. See instructions on back of certificates.

MAY 29 1929

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-002

E 46367

CERTIFICATE OF DEATH

E 46367

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Hebrew aged Home ST. 3-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Esther Blumberg

(a) RESIDENCE NO. 1531 E Pratt ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if foreign birth? 45 yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

a If married, widowed, or divorced HUSBAND of (or) WIFE of: David

6 DATE OF BIRTH (month, day, and year): 1829

7 AGE: Years 100 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Joseph Miller

(Address): 1531 E Pratt St

15 Filed 19 H. HARRISON JONES, M. D. Registrar

A 29123

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 28/29

17 I HEREBY CERTIFY, That I attended deceased from Dec-1928, 19..., to May 28, 19 29

that I last saw her alive on May 26th, 19 29

and that death occurred, on the date stated above, at 10. a. m.

The CAUSE OF DEATH* was as follows:

General arterio sclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Herman Seidel, M. D.

5/29, 1929 (Address) 2404 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Herring Run — DATE OF BURIAL: May 29 19 29

20 UNDERTAKER: S Lorman Bro — ADDRESS 1127 E Balto St

important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 46368 HEALTH DEPARTMENT—CITY OF BALTIMORE 41-002 **E 46368**

CERTIFICATE OF DEATH.

REGISTERED NO. 13-59

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 2594 Druid Park Drive St. Ward)

2-FULL NAME Margaret Kirwan.

(a) RESIDENCE NO. 2594 Druid Park Drive St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm. F. Kirwan

6 DATE OF BIRTH (month, day, and year): June 21 1863

7 AGE — Years: 65 | Months: 11 | Days: 6 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md.

PARENTS

10 NAME OF FATHER: John Weyler,

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Germany

12 MAIDEN NAME OF MOTHER: C. Hentzel

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Germany

14 Informant: Wm F. Kirwan

(Address): 1624 Homestead St.

Filed MAY 29 1929 19 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/27/29 19

17 I HEREBY CERTIFY, That I attended deceased from 5/27/28, 19..., to 5/27/29, 19..., that I last saw her alive on 5/27/29, 19..., and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis.

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) T. Wallace, M. D.

5/28/29 (Address) 321 E. Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem. Date of Burial: May 30 1929

20 UNDERTAKER: Margaret A. Flynn ADDRESS: 142½ Light

MAY 29 1929

tion should be carefully supplied. AGE should be stated EXACTLY. Physicians are requested to fill out this CERTIFICATE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46369

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46369

CERTIFICATE OF DEATH

57

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 305 Somerset Rd ST. 27-457 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Milton Davis

(a) RESIDENCE NO. 305 Somerset Rd Roland Park WARD
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 24 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	5	3.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tobacco Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Francis A. Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sallie L. Long

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant E. Asbury Davis
(Address) 305 Somerset Rd

15 [illegible] 19 [illegible]

HENDERSON JONES, M. D.
Registrar

MAY 29 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27-1929

17 I HEREBY CERTIFY, That I attended deceased from May 17, 1929, to May 27, 1929.

that I last saw him alive on May 27, 1929

and that death occurred, on the date stated above, at 11.15 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Broncho-Pneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Lung findings - Urine + Blood Sugar.

(Signed) Wm Webb Fort M. D.

5/28, 1929 (Address) 20 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	May 29 1929

20 UNDERTAKER and ADDRESS
J. O. Mitchell Sons 1900 Eutaw Place

OF DEATH in plain terms, so that it may be properly classified. Every item is important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 46370

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46370

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Hopkins Hospital St. 5-8 Ward) 198

2-FULL NAME Mamie Johnson

(a) RESIDENCE NO. 1107 Orleans St., Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	26			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) N.C.

PARENTS

10 NAME OF FATHER Henry Johnson

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) N.C.

12 MAIDEN NAME OF MOTHER Annie Davis

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) N.C.

14 Informant Walter Johnson (Bro)
(Address) 304 Hargrove Alley

15 Filed ..... 19 ..... HENDERSON JONES, M. D. Registrar

A 231523

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25/29 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Hemorrhage due to stab wound of heart. Homicide

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? yes

What test confirmed diagnosis? .....

(Signed) [signature] M. D.

5/29/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury cemetery — DATE OF BURIAL May 29 1929

20 UNDERTAKER Lottie Green — ADDRESS 1535 Aisquith

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46371 — PLACE OF DEATH

E 46371 — REGISTERED NO.

CITY OF BALTIMORE: (No. 4709 Park Heights Ave ST.) 27-56 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thomas John Bantz Jr.

(a) RESIDENCE NO. 4709 Park Hts Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 28- 1912

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	16	6	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School-Boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Thos J. Bantz Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Estelle Stevenson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Thos J. Bantz Sr.
(Address) 4709 Park Heights Ave

15 [illegible] 19 C. HARRISON JONES, M. D. Registrar

OF DEATH in plain terms, so that it may be easily understood. important. See instructions on back of certificates.

A 291023

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28 29

17 I HEREBY CERTIFY, That I attended deceased from May, 1926, to May 28, 1929, that I last saw him alive on May 27, 1929 and that death occurred, on the date stated above, at 8 40 P m.

The CAUSE OF DEATH* was as follows:

Tumor of right adrenal gland & liver — type not determined

(duration) 3 yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Apr. 1926

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) Grant Ellard, M. D.

, 19 (Address) 214 Medical Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: 5/31-1929

20 UNDERTAKER: Chas. P. Maus & Son

ADDRESS: 1100 N. Eutaw ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46372

E 46372
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

24-34 90

1-PLACE OF DEATH

City of Baltimore: (No. 1507 1/2 Covington St. St., (Ward)

2-FULL NAME Lillian R. Dasch.

(a) RESIDENCE NO. 1507 1/2 Covington St. St., Ward
(Usual place of abode)

Length of residence in city or town where death occurred 33 yrs. 4 mos. 17 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, [redacted]
(or) WIFE of John C. Dasch.

6 DATE OF BIRTH (month, day, and year) January 9, 1896

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	33	4	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Frederick Thompson.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Mary Chaney.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore, Md.

14 Informant John C. Dasch. (husband)
(Address) 1507 1/2 Covington St.

15 Filed MAY 29 1929 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26, 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inq[illegible]
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:

Acute dilatation of the Heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Eenhardt, M. D.

5/28. 1929 (Address) 1017 E. Charles st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill. DATE OF BURIAL 5-29-29

20 UNDERTAKER E. B. Clarke ADDRESS 1156 West

IMPORTANT—NAME should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill out CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46373

1-PLACE OF DEATH

CERTIFICATE OF DEATH

-161-001

E 46373

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of Baltimore: (No. 320 Ellamont St. 20-10 Ward)

2-FULL NAME James Matthews

(a) RESIDENCE NO. 320 Ellamont St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 2, 1929

7 AGE Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	4	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Norman Matthews

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Beatrice Bethel

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore Md.

14 Informant Beatrice Matthews
(Address) 320 Ellamont St

15 Filed ..... 19.....

HAMILTON JONES, M. D.
Registrar

MAY 29 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/27 1929

17 I HEREBY CERTIFY, That I took charge of the remains deseribed above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Premature Birth

Mal-Nutrition

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. H. Bromberg M. D.

5/29, 1929 (Address) 3601 3rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Star Cemetery

DATE OF BURIAL May 29, 1929

20 UNDERTAKER Mrs Katie R. Williams

ADDRESS 322 N Schroeder St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should sign CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

1-PLACE OF DEATH **E 46374** CERTIFICATE OF DEATH. 161201 **E 46374**

CITY OF BALTIMORE: (No.) St. Vincents Infant Asylum (Street) (WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Markell (Twin #1)

(a) RESIDENCE NO. 182 Cross ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced. (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 27 1929

7 AGE Years ..... Months ..... Days 1 If LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Walter Sloan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Emma Brennan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant .....
(Address) .....

15 Filed ..... 19 ..... Registrar .....

MAY 23 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28 1929

17 I HEREBY CERTIFY, That I attended deceased from May 27, 1929, to May 28, 1929, that I last saw him alive on May 28, 1929, and that death occurred, on the date stated above, at 1.50 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity
(Twin)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Maternal Toxemia

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Clinical

(Signed) Louis A. Hodgson M.D.

5/28, 1929 (Address) 14 Division St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL ..... 19 .....

20 UNDERTAKER Commissioner Health.

ADDRESS .....

MAY 29 1929

mation should be entered. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E ~~46375~~ 46375 (16001)

CERTIFICATE OF DEATH.

E 46375

1-PLACE OF DEATH St. Vincent's Infant Asylum REGISTERED NO.

CITY OF BALTIMORE: (No. 1401 Division St. 24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Markell (Twin #2)

(a) RESIDENCE NO. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 27 1929

7 AGE Years | Months | Days 1 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Walter Stowe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Emma Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant (Address)

15 [illegible] Registrar

MAY 29 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28 1929

17 I HEREBY CERTIFY, That I attended deceased from May 27, 1929, to May 28, 1929, that I last saw him alive on May 28, 1929, and that death occurred, on the date stated above, at 6 30 A. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(Twin)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Maternal Toxemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Louis H. Douglass, M. D.

(Address) 1401 Division St.

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER The Municipal Health.

ADDRESS MAY 2 1929

C. HAMILTON JONES, M. D.

mation should be carefully supplied. Note: Name must be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 46376

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

191~ E 46376

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 3207 Brighton St. 16-67 Ward)

2-FULL NAME Nellie Kraitt

(a) RESIDENCE NO. 3207 Brighton St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 Color or Race White

5 Single, Married, Widowed or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Abraham Kraitt

6 DATE OF BIRTH (month, day, and year) 5-8-80

7 AGE Years 48 Months Days IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Russia
(State or country)

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Bernard Kraitt
(Address) 3207 Brighton

15 [illegible] HAMPTON JONES, M. D.
Registrar

MAY 29 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) May 29 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Pistol Wound of Chest
Homicide
(duration) ..... yrs. Instantaneous

CONTRIBUTORY
(Secondary)
(duration) ..... yrs. mos. ds.

18 Where was disease contracted If not at place of death? 3207 Brighton
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Inquest

(Signed) May 29 [illegible] Coroner, M. D.
(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rehrer Friedlich's — DATE OF BURIAL 5/30 1929

20 UNDERTAKER Jack Levin — ADDRESS [illegible]

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 46377

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46377

CERTIFICATE OF DEATH

REGISTERED NO. 170

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 3207 Brighton St. 16-67 Ward)

2-FULL NAME Abraham Kutt

(a) RESIDENCE NO. 3207 Brighton St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Nettie Kutt

6 DATE OF BIRTH (month, day and year): 1878

7 AGE: Years 50 | Months | Days | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Tailor
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town): Russia
(State or country)

PARENTS

10 NAME OF FATHER: [illegible]

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER: [illegible]

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant: Bernard Kutt
(Address) 3207 Brighton St

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) May 29 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Pistol wound of heart
Suicide (duration) ..... yrs. ..... mos. Sudden

CONTRIBUTORY (Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) May 29 19 (Address) Coroner M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Lebanon Cemetery — DATE OF BURIAL: 5/30 19 29

20 UNDERTAKER: Jack Levin — ADDRESS: 1429 Eastern Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46378

CERTIFICATE OF DEATH.

E 46378

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No. ..... ST 2-4 WARD) 161

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Arnold

(a) RESIDENCE No. 1919 E Lombard ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Hrs yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 14-1929

7 AGE — Years — Months — Days: 14 — If LESS than 1 day, hrs or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Sinai Hospital Balto. Md

PARENTS

10 NAME OF FATHER Thomas Frances Arnold

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER Anne Thelma Engelhart

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Thomas F. Arnold. (Address) 1919 E Lombard St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 28 1929

17 I HEREBY CERTIFY, That I attended deceased from May 14 1929 to May 28 1929 that I last saw her alive on May 28 1929 and that death occurred, on the date stated above, at 12 40 A m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Sinai Hospital

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & autopsy

(Signed) James L Swank M. D.

19 Address: Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer

DATE OF BURIAL: May 29 1929

20 UNDERTAKER: M. W. E. Siffel Sons

ADDRESS: 32 am St

mation should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46379

CERTIFICATE OF DEATH

24

E 46379

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital WARD) 25-11

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Casimir Wiszniewski

(a) RESIDENCE NO. 1420 Cherry St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 9 mos. 5 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 23, 1925

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	9	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child — none

(b) General nature of industry, business, or establishment in which employed (or employer) Home —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Walter Wiszniewski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Sarah Santucz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Sarah Wiszniewski (Address) 1420 Cherry St

15 Filed ..., 19... HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28, 1929

17

I HEREBY CERTIFY, That I attended deceased from May 27, 1929, to May 28, 1929, that I last saw h... alive on May 28, 1929 and that death occurred, on the date stated above, at 2 25 p.m.

The CAUSE OF DEATH* was as follows:

Meningitis (Meningococcic)

(duration) 0 yrs. 0 mos. 5 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) 0 yrs. 0 mos. 3 ds.

18 Where was disease contracted if not at place of death? 1420 Cherry St

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings —

(Signed) Addison Craft Thrb M. D.

5-29 1929 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross & Co. DATE OF BURIAL May 29 1929

20 UNDERTAKER E. L. Ozazewski ADDRESS 1930 Eastern Ave

OF DEATH is plain, legible and important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46380 | 29 | E 46380

1—PLACE OF DEATH

REGISTERED NO. 21-54

CITY OF BALTIMORE: (No. Hebrew aged Home ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rebecca Silverman

(a) RESIDENCE NO. Belvedere & Greenspring ST. AVE. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if foreign birth? 23 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of David Silverman

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Levis

(Address) 1439 E Biddle St

15 Filed [illegible], 19[illegible] SAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/29/29

17

I HEREBY CERTIFY, That I attended deceased from May-20, 1929, to May-29, 1929

that I last saw h[illegible] alive on May-29-, 1929

and that death occurred, on the date stated above, at 7 9 m.

The CAUSE OF DEATH* was as follows:

Chronic Intestinal Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Urine & Kidney Tests

(Signed) Herman Daiches M. D.

May 29 1929 (Address) 2404 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Mt Carmel

DATE OF BURIAL 5/29 1929

20 UNDERTAKER Jack Levis

ADDRESS 1439 E Biddle St

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46381

CERTIFICATE OF DEATH

× 185

E 46381
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St., 4 30 Ward)

2-FULL NAME Henry V. Pohlman

(a) RESIDENCE NO. 11 Carroll St., Ward Annapolis, Md.
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) Feb 4 - 1928

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	1	3 4	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Annapolis. Md

PARENTS

10 NAME OF FATHER Adolph Pohlman

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary Colburn

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Annapolis Md

14 Informant Mrs Harry Colburn
(Address) 15 Carroll St

15 Filed ....., 19.... HARRISON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fractured Skull (Accidental Death)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Annapolis, Md.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Feldy M. D.

5-29. 1929. (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL
Annapolis Md.

DATE OF BURIAL
May 29 1929

20 UNDERTAKER
Jas. S. Taylor & Sons

ADDRESS
Annapolis Md.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46382

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

124 46382

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 218 N. Linwood Ave. ST. 6-11 WARD)

2—FULL NAME WILLIAM H. DICKINSON

(a) RESIDENCE NO. 218 N. Linwood Ave. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A. Dickinson

6 DATE OF BIRTH (month, day, and year) January 9, 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	4	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Musician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER William H. Dickinson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) England

12 MAIDEN NAME OF MOTHER Mary E. Wittington

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Mrs. Mary A. Dickinson (Wife)
(Address) 218 N. Linwood Ave.

15 Filed [illegible] C. HAMILTON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27, 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan. 26, 1929 to May 27, 1929
that I last saw h[illegible] alive on May 26, 1929
and that death occurred, on the date stated above, at 9.05 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

2.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio-Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. H. Jones, M. D.

5/29, 1929 (Address) 1500 E. 33rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cemetery	May. 30, 1929
20 UNDERTAKER Henry Sander & Sons, Inc.	ADDRESS BALTIMORE ST. & BROADWAY.

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46383

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46383

CERTIFICATE OF DEATH

90

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 562 Wilson ST. 14-76 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna Bruce

(a) RESIDENCE NO. 562 Wilson ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eugene Bruce

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER Henry Sifferles

11 BIRTHPLACE OF FATHER (city or town) (State or country) N C

12 MAIDEN NAME OF MOTHER Dalia Sydnor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N C

14 Informant Eugene Bruce

(Address) 562 Wilson St

15 Filed 5-31 19 29 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28/29.

17 I HEREBY CERTIFY, That I attended deceased from May 1929 to May 28 19 29

that I last saw h alive on May 27 19 29

and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis

(duration) yrs. 4 mos. 26 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) B. N. Hatcher, M. D.

5/28 19 29 (Address) 1115 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rustin N. C. DATE OF BURIAL 5-30 1929

20 UNDERTAKER David Carter ADDRESS 916 Eager

OF DEATH in plain terms, so that it may be properly classified. All questions must be answered, if information cannot be obtained, write "unknown" or "none" where necessary. Physicians are required to report cause of death promptly to the Health Department. Carefully read the rules on the back of this certificate. Do not use abbreviations or symbols. Be particularly careful to fill in the date of death, and to sign and address certificate. Every certificate must be filled out in full. Use typewriter or pen and ink. Please write plainly. All items are important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 46384

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 46384

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital (St.) 21-69 (WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Benjamin H Riley

(a) RESIDENCE No. 2693 Dulaney ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Evelyn

6 DATE OF BIRTH (month, day, and year) 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Paper-cutter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't Know

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't Know

14 Informant Mrs Benjamin Riley
(Address) 1049 Roland Heights

15 Filed 1-29-29 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-28 1929

17 I HEREBY CERTIFY, That I attended deceased from 5-24, 1929, to 5-28, 1929, that I last saw h in alive on 5-28, 1929, and that death occurred, on the date stated above, at 5.20 a m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis - Chr
Interstitial Nephritis.
Hypertrophy & Dilatation of Heart
Endocarditis. (duration) Unknown

CONTRIBUTORY (Secondary) Pulmonary Oedema (duration) yrs. 1 mos. 2 ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Norbert C Rehrig, M. D.

, 1929 Address 251 W 40th ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL 4/30 1929

20 UNDERTAKER W W Shriver — ADDRESS 993 Walnut ave

CAUSE OF DEATH in plain terms, so that it may be properly coded. ATION is very important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46385

E 46385

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3154 Leeds St. 20-19 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Allen Keene

(a) RESIDENCE NO. 3154 Leeds St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
m	w	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 2/27/24

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	5	3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country)

PARENTS

10 NAME OF FATHER Geo G. Keene

11 BIRTHPLACE OF FATHER (City or town)

(State or country) md

12 MAIDEN NAME OF MOTHER Eva Wooten

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) md

14 Informant Geo G. Keene

(Address) 3154 Leeds St

15 Filed C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29 1929

17 I HEREBY CERTIFY, That I attended deceased from May 27 1929 to May 29 1929

that I last saw him alive on May 29 1929

and that death occurred, on the date stated above, at 2 9 m.

The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Candida decompensation

(doration) yrs. mos 2 ds.

18 Where was disease contracted

if not at place of death? Same

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clin & Lab tests

(Signed) Fred T. Hyser M. D.

. 19 (Address) 3321 Fulton Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Olivet Cemetery

Date of Burial May 31, 1929

20 UNDERTAKER Charles W. Dill

ADDRESS 3109 Fredk Ave.

N. B.—WRITE LEGIBLY, with pen and ink. All questions should be carefully answered and if information is not supplied, AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46386

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31

E 46386

1—PLACE OF DEATH

REGISTERED NO. 15-60

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST.) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edward B. Cottrell

(a) RESIDENCE NO. 2207 Poplar Grove ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1885

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Edw. B. Cottrell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Alice Douvall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Hospital Records

(Address)

15 Filed , 19 Registrar C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 27, 1928, to May 29, 1929, that I last saw him alive on May 29, 1929, and that death occurred, on the date stated above, at 4.45 P. M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

Hydrothorax

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical and autopsy

(Signed) Henry Smith, M. D.

5-29, 19 29 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Richmond Va — DATE OF BURIAL May 31 1929

20 UNDERTAKER Wm. J. Ticknor & Son — ADDRESS Mott & Ave. Va

IMPORTANT. See instructions on back of certificates.

Spec.—12 9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46387

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. Church Home + Hosp St. 8-16 Ward)

2-FULL NAME Mrs Mary Basch

(a) RESIDENCE NO. 1631 N Bradford St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED E 31

(If dea... a hospita... tion, give ... instead of ... number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wenzel Basch

6 DATE OF BIRTH (month, day, and year) 9/3/1871

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	56	8	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 0 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Germany

PARENTS

10 NAME OF FATHER Albert Pobel

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Stumm

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Wenzel Basch

(Address) 1627 N. Bradford Ave

15 Filed 5/29/1925 C. HAMPSON JONES, M. D. Registrar

Per

29 1925

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/27/1925

17

I HEREBY CERTIFY, That I attended deceased from May 23, 1925, to May 27, 1925, that I last saw h... alive on May 27, 1925, and that death occurred, on the date stated above, at 1.50 P m.

The CAUSE OF DEATH* was as follows:

Pyelo Nephritis

(duration) intermen. yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? Yes Date of 5/23/25

Was there an autopsy? No

What test confirmed diagnosis? 1. Urine Exam 2. Blood chemistry

(Signed) John Moore Jr M. D.

, 19 (Address) Church Home + Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem Date of Burial 5/29/25

20 UNDERTAKER George J. Ruth ADDRESS 1735 Hanford Ave

Spec.—1-10-21—M&T—1500 Blks.

E 46388

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46388

CERTIFICATE OF DEATH.

38

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hosp. St. (or HOSP.)

2-FULL NAME Baby Girl Jacobs

(a) RESIDENCE NO. 102 Werner St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Newborn Infant

6 DATE OF BIRTH (month, day, and year): 5/23/29

7 AGE: Years | Months | Days | If LESS than 1 day, 5 hrs. or 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): Newborn Infant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Wm Jacobs

11 BIRTHPLACE OF FATHER (city or town) (State or country): Personal

12 MAIDEN NAME OF MOTHER: Dale Jacobs

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address)

15 Filed MAY 29 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/23 1929

17 I HEREBY CERTIFY, That I attended deceased from 5/23/29, 1929, to 5/23, 1929, that I last saw h[illegible] alive on 5/23/29, 1929, and that death occurred, on the date stated above, at 5 P.M.

The CAUSE OF DEATH* was as follows:

Newborn Infant

Premature

Of Weeks Gestation

Congenital Lues

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Gross Exam

(Signed) [illegible] M. D.

(Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: 19

20 UNDERTAKER: Municipal Health.

ADDRESS: MAY 28 1929

Exact statement of OCCUPATION is very important. See instructions on back of certificates.

mation should be carefully supplied. Age among
CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec. 1-10-21—M&T—1500 Bks.

E 46389

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161 E 46389

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hosp ST. 20 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Brooks

(a) RESIDENCE NO. Park Ave Towson ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Newborn

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years | Months | Days | If LESS than 1 day: hrs. or 46 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Newborn Infant

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer: Stillborn

9 BIRTHPLACE (city or town) (State or country): Balt md

PARENTS

10 NAME OF FATHER: Daniel Brooks

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Co md

12 MAIDEN NAME OF MOTHER: Rose Bateman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Co Md

14 Informant

(Address)

15 C. HAMPSON JONES, M. D. Registrar

MAY 29 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/21 1929

17 I HEREBY CERTIFY, That I attended deceased from May 5/21, 1929, to May 5/21, 1929, that I last saw him alive on 5/21, 1929, and that death occurred, on the date stated above, at 3.40 m.

The CAUSE OF DEATH* was as follows:

Premature Infant

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) A. J. Usher M. D.

, 19 29 (Address) University Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER: Dept of Public Health

ADDRESS

MAY 29 1929

mation should be carefully supplied. Age should be given in years. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46390

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

72 E 46390

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 19 E. 22nd ST., 12-50 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John E. Hussey

(a) RESIDENCE NO. 19 E. 22nd ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. 9 mos. 23 ds. How long in U. S., if foreign birth? - yrs. - mos. - ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) August 6, 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	9	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Martin Hussey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Plunkett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Miss Anna G. Hussey

(Address) 19 E. 22nd Street

15 Filed ..... 19 C. HAMPSON JONES, M. D. Registrar

Y 291929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28th 1929

17 I HEREBY CERTIFY, That I attended deceased from May 1st, 1929, to May 28th, 1929

that I last saw him alive on May 28th, 1929

and that death occurred, on the date stated above, at 7.45 P m.

The CAUSE OF DEATH* was as follows:

Locomotor Ataxia

(duration) 15 yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Reginald F. Tonry, M. D.

19 (Address) 414 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Mary's Cem. Govans	5/29 1929

20 UNDERTAKER Henry W. Meads & Edgar H. Calvert ADDRESS

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 46391 HEALTH DEPARTMENT—CITY OF BALTIMORE E 46391

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1302 S. Highland Ave. WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Martha A. Coe

(a) RESIDENCE NO. 1302 S. Highland Ave ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec. 12. 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	5	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md.

PARENTS

10 NAME OF FATHER Wm. H. Coe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md

12 MAIDEN NAME OF MOTHER Laura J. Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto, Md.

14 Informant Anna J. Reckenbeger

(Address) 1302 S. Highland ave

15 5-29-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28-1929

17 I HEREBY CERTIFY, That I attended deceased from July 28, 1928, to May 28, 1929, that I last saw her alive on May 28 1929 and that death occurred, on the date stated above, at 9.45 P. m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What tests confirmed diagnosis? Physical Signs

(Signed) I. B. Bronushas, M. D.

5-29, 1929 (Address) 3037 O'Donnell St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cemetary — DATE OF BURIAL May 31 1929

20 UNDERTAKER George N. Zirkler — ADDRESS 1737 E Eager St.

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46392 — CERTIFICATE OF DEATH — **E 46392**

REGISTERED NO. 74005

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 106 N. Streeper ST., 6-11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Julia Sweeney

(a) RESIDENCE NO. 106 N. Streeper ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If foreign birth? 50 yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 11 1857 ~~1858~~

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	7	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Margaret Fields
(Address) 106 N. Streeper St.

15 Filed 7-3-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28. 1929

17 I HEREBY CERTIFY, That I attended deceased from 5-25, 1929 to 5-28, 1929 that I last saw her alive on 5-28 1929 and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows: Arterio Sclerosis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J. Lovell, M. D.

6/4 1929 (Address) 4/13/29 Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Belm. — DATE OF BURIAL May 31 1929

20 UNDERTAKER George W. Zirkin — ADDRESS 1737 Eager St

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Janowicz

E 46393 HEALTH DEPARTMENT—CITY OF BALTIMORE E 46393

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 6609 Pine St.) 7-26 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Janowicz

(a) RESIDENCE No. 6609 Pine ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 8 1918

7 AGE: Years 11 Months — Days 20 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School boy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Co. Sparrows Point Md

PARENTS

10 NAME OF FATHER: Frank Janowicz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Mary Kolweder

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto city

14 Informant: Frank Janowicz (Address) Dundalk, Md

15 May 29 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 28 1929

17 I HEREBY CERTIFY, That I attended deceased from Apr 21, 1929, to May 28, 1929, that I last saw her alive on May 28, 1929, and that death occurred, on the date stated above, at 5 00 P m.

The CAUSE OF DEATH was as follows:

Leukaemia

About 1 (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Intestinal Hemorrhage

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. M. Carmine M. D.

(Address) Dundalk. Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary Mary — DATE OF BURIAL: 31 1929

20 UNDERTAKER: John McKeber 401 S — ADDRESS: Chester

mation should be carefully supplied. Any blanks must be explained. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

y 29 1929

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46394

CERTIFICATE OF DEATH.

E 46394

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 726 N. Caroline ST. 10-13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Estella Delaman

(a) RESIDENCE No. 726 N. Caroline ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	col.	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 10-13-1869 Colored

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
59		7	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto. City (State or country)

PARENTS

10 NAME OF FATHER Wm Jones

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Estella Wms

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant William Delaman (Address) 726 N Caroline

15 Registrar C. HAMPSON JONES, M. D.

MAY 29 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/28 1929

17

I HEREBY CERTIFY, That I attended deceased from Jan 1, 1929, to May 28, 1929.

that I last saw her alive on May 26, 1929,

and that death occurred, on the date stated above, at 1 30 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of Rheumatic Endocarditis (Cancer)

(duration) 2 yrs, — mos — ds.

CONTRIBUTORY (Secondary) Heart disease

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) Jas R. Blake, M. D.

5/27. 1929 (Address) 924 Aisquith

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL May 31 1929

20 UNDERTAKER Robert H. Williams — ADDRESS 1515 McCulloh St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause is very important. See instructions on back of certificates.

Spec.—8-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46395

CERTIFICATE OF DEATH

REGISTERED NO. E 46395

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2211 Bryant Ave ST., 13-57 WARD)

2—FULL NAME Sarah Blum

(a) RESIDENCE NO. 2211 Bryant Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 40yrs ds. How long in U. S., If foreign birth? yrs. mos. ds. 40

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6 If married, widowed, or divorced (HUSBAND) (WIFE) of Bernhardt Blum

6 DATE OF BIRTH (month, day, and year): June 15-1863

7 AGE: Years 65 | Months 11 | Days 14 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Poneviz, Russia

PARENTS

10 NAME OF FATHER: Harry Schwartz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poneviz Russia

12 MAIDEN NAME OF MOTHER: Dora Doane

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poneviz Russia

14 Informant: Morris Schwartz

(Address) 2209 Bryant Ave

15 [illegible] HAMPSON JONES, M. D.
Registrar

MAY 30 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5-29-29

17 I HEREBY CERTIFY, That I attended deceased from 1-2-, 1927, to 5-29-, 1929 that I last saw h[illegible] alive on 5-29, 1929 and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus 10yrs.

(duration [illegible] yrs. mos. ds.)

CONTRIBUTORY (Secondary): Oedema of Lung

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. Pivek, M. D.

5-29-, 1929 (Address) 2202 North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ohab Shalom Cem — DATE OF BURIAL: 5/30 1929

20 UNDERTAKER: Jack Lewis — ADDRESS: 1439 E. Balto St

Of DEATH in plain writing, as they are important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 46396

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

48 E 46396

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 111 W See ST. 27-30 (WARD)

2-FULL NAME John V. B. Cochran

(a) RESIDENCE NO. 111 W. See ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

mation should be carefully supplied. AGE should be stated EXACTLY. Any uncertainty in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret Cochran

6 DATE OF BIRTH (month, day, and year): Feb 22 1852

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
77	3	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): 10 years

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Carroll Co Mary Land

PARENTS

10 NAME OF FATHER: G. Washington Cochran

11 BIRTHPLACE OF FATHER (city or town) (State or country): Carroll Co Mary Land

12 MAIDEN NAME OF MOTHER: Gareth Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Carroll Co Mary Land

14 Informant: Margaret Cochran

(Address) 111 W. See

MAY 30 1929 19 C. HAMILTON JONES, M. D. Registrar

By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 28 1929

17

I HEREBY CERTIFY, That I attended deceased from Apr 26 1929 to May 28 1929 that I last saw him alive on May 28 1929 and that death occurred, on the date stated above, at 2 30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of skin -

(duration) 1 yrs. 9 mos — ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) — yrs. 1 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of Apr 14 1928

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Lucy Grauchen M. D.

5/28, 1929 (Address) 122 W See St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Airy, Md via Auto

DATE OF BURIAL: May 30 1929

20 UNDERTAKER: John F. Denny

ADDRESS: 715 Light St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46397

CERTIFICATE OF DEATH

3/ **E 46397**

1—PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2748 Tivoly ave ST., 9-46 WARD)

2—FULL NAME Effie Mai Le-bruyer

(a) RESIDENCE NO. (Usual place of abode) 2748 Tivoly ave ST., ... WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. ... mos. ... ds. How long in U. S., if foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of

6 DATE OF BIRTH (month, day, and year): May 5 1908

7 AGE: Years 21 | Months | Days 23 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: Philip M. Le Bruyer

11 BIRTHPLACE OF FATHER (city or town) (State or country): City

12 MAIDEN NAME OF MOTHER: Rhoda Cohen

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Alexandria Va.

14 Informant: Philip M. Le Bruyer (Address) 2748 Tivoly ave

15 ..... 19 ..... HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 28-1929

17 I HEREBY CERTIFY, That I attended deceased from March 5 19 29 to May 28 19 29

that I last saw h alive on May 28 19 29

and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Exhaustion - Toxaemia

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Pulmonary Tuber culosis (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of ...

What test confirmed diagnosis? Physical Exam

(Signed) Claud Smink, M. D.

(Address) 4 202 Stricker St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cathedral Cem

DATE OF BURIAL: May 31 19 29

UNDERTAKER: John G. Moran

ADDRESS 3006 E. Baltimore

important. See instructions on back of certificates.

A 351929

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46398

CERTIFICATE OF DEATH

E 46398

1-PLACE OF DEATH

City of Baltimore: (No. 306 N. Calhoun St., 5-4 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jas. Hunter

(a) RESIDENCE NO. 306 N Calhoun St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Mal	Col	Single

5a If married, widowed, or divorced
HUSBAND of —
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 5, 1928

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
	7	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Chas. Boone

11 BIRTHPLACE OF FATHER (city or town)
(State or country) N. C

12 MAIDEN NAME OF MOTHER Bertha Hamlin

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) S. C

14 Informant Mrs. Hunter
(Address) 306 N. Cal Lawn

15 Filed 19 HAMPSON JONES, M. D.
Registrar
By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 25 1929

17 I HEREBY CERTIFY, that I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) (No Coder)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. H. Browne M. D.

May 30. 1929 (Address) 3601-3 N. Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL May 30, 1929

20 UNDERTAKER Mrs. Katie R. Williams

ADDRESS 322 N. Schroeder

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—3-29-28—L. F. S.—800 lbs.

Harrison

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 46399

CERTIFICATE OF DEATH

E 46399

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 717 W. Cross St. ST. 21-29 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry H. Harrison

(a) RESIDENCE NO. 717 W. Cross St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 2, 1926

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	2	10	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER George H. Harrison

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Catherine Bartel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Catherine Harrison

(Address) 717 W. Cross St.

15 MAY 30 1929 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 17th., 1929, to May 27th., 1929, that I last saw h[illegible] alive on May 27th., 1929 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Otitis Media Acute

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Pneumonia (lobar)

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw. Weinlacker, M. D.

5/28 19 (Address) 24 N. Fulton Ave.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	May 30 19 29
20 UNDERTAKER	ADDRESS
Margaret G. Flynn	1482 Light St

important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 46400

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

84 E 46400

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Home for Incurables ST. 10-14 WARD)

2-FULL NAME Fannie E. Gartrell

(a) RESIDENCE No. 721 E Biddle ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47 ~~50~~	7	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick Co. Md.

PARENTS

10 NAME OF FATHER Edward Gartrell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Frederick Co. Md.

12 MAIDEN NAME OF MOTHER Rachael Gillis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Carroll Co. Md.

14 Informant Home of Incurables (Address) City

15 MAY 30 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/30 1929

17 I HEREBY CERTIFY, That I attended deceased from May 24, 1926 to May 29, 1929

that I last saw her alive on May 29, 1929

and that death occurred, on the date stated above, at 1.15 a. m.

The CAUSE OF DEATH* was as follows:

Paralysis Agitans

5 (duration) yrs. — mos — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) W. B. Mayo, M. D.

5/30 1929 (Address) Medical Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Taylorsville Md

DATE OF BURIAL 6/1 1929

20 UNDERTAKER Wm Cook

ADDRESS 1717 St Paul St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Cor.—10-16-29—A Co.—100 Bks.

E 46401

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

182 E 46401

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Foot of Bush St. 5-1-29 St.) (Ward)

2-FULL NAME Frank Fondaconi.

(a) RESIDENCE NO. 618 S. Fremont Ave. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 13 yrs. 1 mos. 25 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) April 2, 1916

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	13	1	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Raffaele Fondaconi.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Italy.

12 MAIDEN NAME OF MOTHER Regina Costantino.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Italy.

14 Informant Regina Fondaconi. (mother)
(Address) 618 S. Fremont Ave.

(Filed) MAY 30 1929, 19.. HAMILTON JONES, M. D. Registrar

KOH.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning.
Accidental fall from a raft while playing about the water.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto Leinhardt, M. D.

5/20, 1929 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem. DATE OF BURIAL 5/31/29 19

20 UNDERTAKER George J. Butler ADDRESS 1235 Hanover

MAY 30 1929

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46402

CERTIFICATE OF DEATH

131

REGISTERED NO. E 46402

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 37 S Ann ST. 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie M. Dippel

(a) RESIDENCE NO. 37 S Ann ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martin W. E.

6 DATE OF BIRTH (month, day, and year) March 27 1877

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	52	2	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) Pittsburg Pa.
(State or country)

PARENTS

10 NAME OF FATHER Joseph Leiser

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Theresa Ming

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Gertrude Goldstein

(Address) 37 S Ann St

15 [illegible] CHAMPION JONES, M. D.
Registrar

MAY 30 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1929

17 I HEREBY CERTIFY, That I attended deceased from May 23 1929, to May 27 1929, that I last saw h[illegible] alive on May 27 1929 and that death occurred, on the date stated above, at 11 P.M.

The CAUSE OF DEATH* was as follows:

Acute Pyelo Nephritis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Cardiac Collapse

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Herman J. Grening, M. D.

(Address) 1400 Eastern Ave May 30, 1929

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	5/31/29 19
20 UNDERTAKER Healy Anderson	ADDRESS 1723 Hoffman

OF DEATH in plain terms, so that it may be properly classified. important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46403

CERTIFICATE OF DEATH

E 46403

REGISTERED NO. 29

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3610 Mt Pleasant ave. WARD) 26-37

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Hannie M. Pultt

(a) RESIDENCE NO. 3610 Mt Pleasant ave WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): May 6 1912

7 AGE: Years 17 | Months | Days 22 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Broom Works

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Salvesta F. Pultt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Nellie Grimett

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Salvesta F. Pultt

(Address): 3610 Mt Pleasant ave

15 Filed: MAY 31 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/28/29

17 I HEREBY CERTIFY, That I attended deceased from Oct 25, 1928, to May 28, 1929, that I last saw h.e alive on May 27, 1929 and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Chronic Endo + Myocarditis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Heart & Kidneys Examination

(Signed) D Stanton, M. D.

5/30, 1929 (Address) 2015 Ellwood ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidial. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary — DATE OF BURIAL: May 31 1929

20 UNDERTAKER: Kendall & Kloppel — ADDRESS: 300 S Eden St

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46404

E 46404

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 820 Warner St. St. 21-31 Ward)

2-FULL NAME Josaphine Brown.(C)

(a) RESIDENCE NO. 820 Warner St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	Widow.

5a If ~~XXXXX~~ widowed, of ~~XXXXX~~ ~~XXXXX~~ (or) WIFE of John Brown.(C)

6 DATE OF BIRTH (month, day, and year) April 1864

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	65	1	----	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country) ~~XXXXXXXXXXXXXXXXXX~~

PARENTS

10 NAME OF FATHER John Brashiers.(C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Annapolis Md.

12 MAIDEN NAME OF MOTHER Grace Parker.(C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Annapolis, Md.

14 Informant Grace Brown.(C) daughter.
(Address) 820 Warner St.

15 ~~XXXXXXXXXX~~ C. HAMPSON JONES, M. D.
Registrar

MAY 31 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:

Organic disease of the heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M Steinhardt, M. D.

5/28, 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn

DATE OF BURIAL May 31 1929

20 UNDERTAKER John H Tradin

ADDRESS 1027 Lemmon Mt

8.—WRITE PLAINLY, with indelible pencil. All questions should be answered. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46405

HEALTH DEPARTMENT—CITY OF BALTIMORE

41

CERTIFICATE OF DEATH

E 46405

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 7-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ella Robinson

(a) RESIDENCE NO. 1611 Waldo ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statements of conditions are important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Days work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

0440

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Jeremiah Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Records of

(Address) Baltimore City Hospitals

15 Filed MAY 31 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 28, 1929 to May 29, 1929,

that I last saw her alive on May 29, 1929

and that death occurred, on the date stated above, at 2:45 P. m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar bilateral
Meta - Streptococcus
Septicemia - Focus undetermined
(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Physician - autopsy

(Signed) Harvey [illegible] M. D.

. 19 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Calvary	June 2, 1929
20 UNDERTAKER John H. Fowden	ADDRESS 1027 Hanover St.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46406

CERTIFICATE OF DEATH

E 46406

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 21-29 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Lillian Shenbrook

(a) RESIDENCE NO. 1254 Sargent St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? 28 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Leonard Shenbrook

6 DATE OF BIRTH (month, day, and year) Feb 25 1909

7 AGE Years 20 Months 3 Days 4 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER Tim Callahan

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Balto

12 MAIDEN NAME OF MOTHER Sadie Mahoney

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto

14 Informant Mrs Leonard Shenbrook

(Address) 1254 Sargent St

15 Filed MAY 31 1929 16 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/29/29

17 I HEREBY CERTIFY, That I attended deceased from 5/8/29, 19..., to 5/29/29, 19..., that I last saw her alive on 5/29/29, 19..., and that death occurred, on the date stated above, at 10:30 A.M.

The CAUSE OF DEATH* was as follows:

Hyperthyroidism

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) Sudden yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? yes Date of one year ago and 5/29/29

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) J. S. Weintraub, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters Cem. Date of Burial 6/1 29 19

20 UNDERTAKER Wm Fowlers ADDRESS 1200 W Fayette.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—600 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46407

E 46407

1—PLACE OF DEATH

REGISTERED NO. 18Y-001

CITY OF BALTIMORE: (No. 821 N. Fulton Ave. ST., 16-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna Florence Henrix.

(a) RESIDENCE NO. 821 N. Fulton Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of late Thomas J. Henrix

6 DATE OF BIRTH (month, day, and year) Sept 5th. 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	73	8	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER William Sprigg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Louise Powers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Carroll Irving

(Address) 6930 South Shore Drive Chicago Ill.

15 Filed MAY 31 1929 HARRISON JONES, M. D. Registrar

OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29. 29

17

I HEREBY CERTIFY, That I attended deceased from May 24, 1929, to date of death, 19

that I last saw h-- alive on May 29, 1929

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Carbon Monoxide (Coal) Poisoning, Was Accidental (duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Asthma

Long (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Pinckney Lee Harris, M. D.

5/30/1929 (Address) 824 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem

DATE OF BURIAL 5/31/29

20 UNDERTAKER Harry White

ADDRESS Lond

Spec.—1-10-21—M&T—1500 Bks.

E 46408 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100 001

E 46408

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No. ..... ST. 6-10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Arnold Lerner

(a) RESIDENCE NO. 2132 E. Balt. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 11 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 15-1928

7 AGE — Years: 1 | Months: | Days: 15 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto city Md

PARENTS

10 NAME OF FATHER: Joe Lerner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Bessie Chamish

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Jack Lewis

(Address) 1439 E. Balto St

15 Filed ..... 19 ..... HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/30 1929

17

I HEREBY CERTIFY, That I attended deceased from May 25, 1929, to May 30, 1929, that I last saw h alive on May 30, 1929, and that death occurred, on the date stated above, at 9.45 A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Emphysema

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 5/27/29

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) S. H. Linde, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mortimer Circle — DATE OF BURIAL: 5/31 1929

20 UNDERTAKER: Jack Lewis 1439 E Balto St — ADDRESS

MAY 31 1929

mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 46409 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

E 46409

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hospital (St.) (13-59) (Ward)

2-FULL NAME Jennie Goldstein

(a) RESIDENCE NO. 2435 Eutaw Place. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Goldstein

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Elyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rosenstein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Sam Goldstein (Address) 2435 Eutaw Place

15 Date received MAY 31 1927 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/30 1927

17 I HEREBY CERTIFY, That I attended deceased from 5/15 1927, to 5/30 1927, that I last saw her alive on 5/30 1927, and that death occurred, on the date stated above, at 11:30 A m.

The CAUSE OF DEATH* was as follows:

Acute dilatation of heart (right side)

(duration) 10 minutes yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death? Sinai Hosp.

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? Physical examination

(Signed) H. Eliz, M. D.

5/30 1927 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rodeph Shalom Cem

DATE OF BURIAL: 5/31 1927

20 UNDERTAKER Jack Levin

ADDRESS 1439 Eutaw St

mation should be carefully supplied. AGE should be stated EXACTLY. Fractions CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-25—L. F. S.—500 Bks.

SKARZINSKI

100-001

E 46410

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46410

CERTIFICATE OF DEATH

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 728 So Dupham ST. 7-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jozefa Skarzinski

(a) RESIDENCE NO. 728 So. Dunham ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Infant

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 7-1-1929

7 AGE — Years | Months: 3 | Days: 29. | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Bronislaw Skarzinski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Helena Jajanc

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Bronislaw Skarzinski
(Address) 728 So Dunham St.

15 Filed MAY 31 1929, 19

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5-30-29

17 I HEREBY CERTIFY, That I attended deceased from May 29, 1929, to May 30, 1929

that I last saw her alive on May 30, 1929

and that death occurred, on the date stated above, at in.

The CAUSE OF DEATH* was as follows:

(Bronchopneumonia
(Simple) —

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Cordiae Paralysis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J. Ryan, M. D.

(Address) 801 N Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary cemetery — DATE OF BURIAL: May 31 1929

20 UNDERTAKER: George A. Weber — ADDRESS: [illegible]

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Bents

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 46411

CERTIFICATE OF DEATH

E 46411

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 517. So Potomac. ST. 1-2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME. Clara R. Bento

(a) RESIDENCE NO. 517 So Potomac ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (Write the word): Infant.

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 24 - 1928.

7 AGE — Years: | Months: 7 | Days: 6 | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore md.

PARENTS

10 NAME OF FATHER: Frederick Bent

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. md.

12 MAIDEN NAME OF MOTHER: Clara Sinkozenstyn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto, md.

14 Informant: Clara Bent.

(Address) 517 So. Potomac St.

15 Filed MAY 1 1929 19 HARRISON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5-30-29

17 I HEREBY CERTIFY, That I attended deceased from 5-26 19 29 to 5-30 19 29

that I last saw h alive on 5-29 19 29

and that death occurred on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows: Fatal Anemia

4

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Pending

(Signed) Fred Bent Phys.

5-30-29 (Address) 500 N Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislaus Cem.

DATE OF BURIAL: May 31 1929.

20 UNDERTAKER: George A. Weber

ADDRESS: 705 S. Ann St.

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46412

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46412

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 18-26 90

CITY OF BALTIMORE: (No. 246 N. Arlington ST., 18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Maria Carpenter

(a) RESIDENCE NO. 246 N. Arlington ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Fem	Col'd	Wid

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unk

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Essex Co Va

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Amos Anderson

(Address) 156 E-35th St

15 Filed May 31, 1929 WILLIAM JAMESON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29/29

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1929, to May 29 1929, that I last saw h alive on May 29, 1929 and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Organic Disease
Heart
Ovarian Cyst

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pulm Adema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) 30/29 H H Norwood, M. D.

19 (Address) 939 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
National Cem.	5-31 1929
20 UNDERTAKER Daniel Easter & Co	ADDRESS 916

OF DEATH in plain terms, so that it may be properly classified. important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46413

CERTIFICATE OF DEATH

90-E 46413

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1343 Division St., 17-24 Ward)

2-FULL NAME Edw. Wallace.

(a) RESIDENCE NO. 1343 Division St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK. The information called for on this certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	Col	Married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1894

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
35	34			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Presser & Cleaner Clothes.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Bath Md
(State or country)

PARENTS

10 NAME OF FATHER Walter Wallace

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Minnie Kirby

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Walter Wallace
(Address) 1343 Division

15 Filed ..... 19 .....
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 24th 1929

I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, autopsy or inquiry.

thereon and from the evidence obtained by said inquest, autopsy or inquiry find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) ..... yrs. 6 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Regular

(Signed) May 27th 1929 F. C. Link, M. D.
(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	5-31 1929

20 UNDERTAKER Daniel Carter ADDRESS 916 Pa ave

[illegible] THOMPSON JONES, M.D.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46414

CERTIFICATE OF DEATH.

179

E 46414

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph's Hospital St. 27-53 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME HARRY E. GLOCK

(a) RESIDENCE NO. 615 Elmwood Road St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of - - -

6 DATE OF BIRTH (month, day, and year) December 19,1913

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
15	16	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schoolboy

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER George A. Glock

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Katherine Erker

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mr. George A. Glock (Father)
(Address) 615 Elmwood Road

15 Filed ..... 19.... HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Toxemia due to accidental burns
(While filling his motorcycle tank gasoline overflowed and became ignited at 6521 Belair Road. 3/29

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

(Signed) John K. Ficker, M. D.
(Coroner)

5/30/29 (Address) 509 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Jerusalem Cemetery Date of Burial June 1 1929

20 UNDERTAKER Henry Sander & Sons, Inc ADDRESS Baltimore St. & Broadway

N. B.—WRITE plainly and with ink. Every question should be carefully answered. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 46415 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. E 46415

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1075 W. Fayette ST. 18-16 WARD) 129

2-FULL NAME Mary E Johnson

(a) RESIDENCE No. 1075 W Fayette ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: W White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced (or) WIFE of: George W. Johnson

6 DATE OF BIRTH (month, day, and year): Unknown 1861

7 AGE: Years: Abt. 67 | Months: ✓ | Days: ✓ | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: James Tatem

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Catherine Isaac

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Earl L. Johnson

(Address): 3544 Pinkney Ave

15 Date received: MAY 31 1929 H. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/28 1929

17 I HEREBY CERTIFY, That I attended deceased from 5/13 1929, to 5/28 1929.

that I last saw her alive on 5/28 1929

and that death occurred, on the date stated above, at 7 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Arteriosclerosis & Asthenia

(duration) yrs mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Out of town

Did an operation precede death? ✓ Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Stella Hemming M. D.

5/29 1929 (Address) 2000 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cemetery

DATE OF BURIAL: May 31 1929

20 UNDERTAKER: Ezekiel B Cook

ADDRESS: 1003 West Baltimore St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

AY 31 1929

Spec.—2-29-28—L. F. S.—500 Bks.

E 46416

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46416

REGISTERED NO. 17-50

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2527 Grunmount St. WARD 17

2—FULL NAME Thelma Marie Hauser

(a) RESIDENCE NO. 2527 Grunmount St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 21, 1928

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
		10	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER George Hauser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Blanche Wiser

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant George Hauser

(Address) 2527 Grunmount St

15 MAY 31 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 26th, 1929, to May 28th, 1929, that I last saw h[illegible] alive on May 28th, 1929 and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Geo. Furgerson III M. D.

5/29/1929 (Address) 401 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 5/31 1929

20 UNDERTAKER Wm. E. Cook

ADDRESS 1217 E. Baltimore St

OF DEATH in plain terms, so that it may be properly classified. Last statement of occupation is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 46417

CERTIFICATE OF DEATH

E 46417

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 5405 Walther Ave ST., 24 WARD)

2—FULL NAME Dennie Stevenson

(a) RESIDENCE NO. 5405 Walther Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Bl	Widow

a If married, widowed, or divorced HUSBAND of (or) WIFE of Edwin

6 DATE OF BIRTH (month, day, and year) June 29 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Crisfield Md

PARENTS

10 NAME OF FATHER Seth H Blader

11 BIRTHPLACE OF FATHER (city or town) (State or country) Crisfield Md

12 MAIDEN NAME OF MOTHER Emely Sterling

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Crisfield Md

14 Informant Mrs Alberta Brown

(Address) 5405 Walther ave

Filed MAY 31 1929, 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29-1929

17 I HEREBY CERTIFY, That I attended deceased from May 25, 1929, to May 29, 1929, that I last saw h alive on May 29, 1929, and that death occurred, on the date stated above, at 1:45 p.m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

& Toxaemia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Clay Smith, M. D.

5/31 19 29 (Address) 4 208 Hampstead Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 6/1 19 29

20 UNDERTAKER H McCook 1217 St Paul St

ADDRESS

CERTIFICATE OF DEATH in plain terms, so that it may be properly classified. Every item important. See instructions on back of certificates.

MAY 31 1929

HAMPSON JONES, M. D.

Spec. 6-8-19 H. P. Co.—1000 Blks.

E 46418

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46418

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE, No. 1818 N Dallas St. (8-17 WARD) REGISTERED NO.

2-FULL NAME Lena Virginia Eyerly

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE. No. 1818 N Dallas St. ST., WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 84 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F.	White	widow

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Jacob S Eyerly.

6 DATE OF BIRTH (month, day, and year) June 2 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84 +	11	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Uppeman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Lydia Tracy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Son-John H. Leonard

(Address) Selma nr Halethorpe

15 Filed MAY 31 1929 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29 1929

17 I HEREBY CERTIFY, That I attended deceased from May 26, 1929, to May 29, 1929, that I last saw her alive on May 28, 1929, and that death occurred, on the date stated above, at 6.55 P. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

Arteriosclerosis & hypertension.

CONTRIBUTORY (Secondary) Cerebral hemorrhage (duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? (duration) yrs. mos. 1 ds.

Did an operation precede death? None Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Chas. Sanders M. D.

5/30, 1929 (Address) 1517 E Northave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	6/1 1929
20 UNDERTAKER	ADDRESS
W M Cook	1217 Park

mation should be carefully supplied. AGE should be stated EXACTLY. If LESS than CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46419

CERTIFICATE OF DEATH

E 46419

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. En route to University Hospital St., Ward)

2-FULL NAME Della M. Hutchins

(a) RESIDENCE NO. 659 W. Fayette St., Ward

(Usual place of abode)

Length of residence in rity or town where drath ocrurrrd 20 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color of Rare: White

5 Single, Married, Widowed or Divorced, (write the word): Widowed

5a If married, ~~Widowed, or divorced~~ HUSBAND of (or) WIFE of: Robert Hutchins

6 DATE OF BIRTH (month, day, and year): Sept. 10 - 1871

7 AGE: Years 57 | Months 8 | Days 18 | IF LESS than 1 day ...hrs. or ...min.

8 OCCUPATION OF DECEASED
(a) Tradr, profession or partirular kind of work: Housework
(h) General nature of industry, business, or rstablishment in whirh employed (or employer)
(r) Name of employer

9 BIRTHPLACE (~~city or town~~)
(State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Daniel Miller

11 BIRTHPLACE OF FATHER (rity or town)
(State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Bowers

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Md

14 Informant: Bertha B. Dailey
(Address): Glen Echo, Md

15 Filed ... C. HAMPSON JONES, M. D. Registrar
Per ...

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 28, 1929

17 I HEREBY CERTIFY, That I took charge of the remains drscribed above, held an inquiry (Inquest, autopsy or inquiry.) thrrron and, from thr evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Angina Pectoris

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Serondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disrase rontrarted If not at place of death?

Did an operation prrcede death? No Date of

Was there an autopsy? No

What test rontirmed diagnosis?

(Signed) Eugene Gilbert M. D.

5-29-1929 (Address) 2739 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Mrans and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hagerstown Md — DATE OF BURIAL: 5/31/29

20 UNDERTAKER: Wm Cook — ADDRESS: 1217 St Paul St

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-20-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46420

CERTIFICATE OF DEATH

52

E 46420

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS

REGISTERED NO.

CITY OF BALTIMORE: (No. 6-13 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Cordelia Hogan

(a) RESIDENCE NO. 1918 E. Chase ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married~~, Widowed, or ~~Divorced~~, (write the word): ~~Unknown~~ Widowed

5a If ~~married, widowed, or divorced~~ ~~HUSBAND~~ of (or) WIFE of: Matthew Hogan

6 DATE OF BIRTH (month, day, and year): Aug 13 - 1850 ~~Unknown~~

7 AGE: 78 Years 79 | Months 9 | Days 16 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: George Eckert

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Theresa Anne

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Records of

(Address): Baltimore City Hospitals

15 Filed MAY 31 1929 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 29, 1929

17 I HEREBY CERTIFY, That I attended deceased from September 23, 27 to May 29, 1929, that I last saw h... er alive on May 29, 1929 and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Senile Hypertrophic arthritis

(duration) ... yrs. 18 mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no What test confirmed diagnosis? Physical Exam

(Signed) ... , M. D.

, 19 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: June 1st 1929

20 UNDERTAKER: Robt J. Turner Sons — ADDRESS: 1422 Broadway

OF DEATH in plain terms, so that it may be properly classified. Exact statements of important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46421

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 46421

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Baltimore City Hosp. ST., 26-38 WARD)

2—FULL NAME Clara Graham

(a) RESIDENCE NO. Maple + Ridge Aves ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem.	W hite	Unknown

3a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Nov. 30-1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	1	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER Geo. Graham

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Mrs. Grace Cochran
(Address) 2118 Lempson St.

15 Filed 6 HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/27/29

17 I HEREBY CERTIFY, That I attended deceased from 12/16, 1926, to 5/27, 1929

that I last saw h.r alive on 5/27, 1929

and that death occurred, on the date stated above, at 3:20 a. m.

The CAUSE OF DEATH* was as follows:

Senility, Arteriosclerosis
Myocarditis - Arterial
Fibrillation

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. L. Lumpkin, M. D.

5/28. 1929 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet Cemetery	May 31 1929
20 UNDERTAKER	ADDRESS
George L. Schwartz	701 Park Ave

OF DEATH in plain terms, so that it may be properly classified. Every question must be answered. Write plainly with pen and ink. Use no abbreviations. All dates must be complete. Ditto marks must not be used. Every certificate must be signed. Every item is important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 46422 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 E 46422

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5500 Hilltop Ave ST. 27-42 WARD)

2-FULL NAME Helen C. Wolff

(a) RESIDENCE NO. 5500 Hilltop Ave ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Walter A. Wolff

6 DATE OF BIRTH (month, day, and year) Dec. 31-1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	41	4	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Rudolf Schroeder

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Anna Schmitt

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Walter A. Wolff
(Address) 5500 Hilltop Ave

15 Filed ..... 19 .....

Registrar.

HARRISON JONES

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28 1929

17

I HEREBY CERTIFY, That I attended deceased from Jan 2, 1929, to May 28, 1929, that I last saw h alive on May 27, 1929, and that death occurred, on the date stated above, at 1:45 p.m.

The CAUSE OF DEATH* was as follows:

Exhaustion Toxaemia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Carcinoma of Stomach

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of April 15 29

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) Chas Smith, M. D.

5/25 1929 (Address) 4202 [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Emmanuel Cemetery	May 31 1929
20 UNDERTAKER	ADDRESS
George L. Schwartz	210 Fulton Ave

mation should be carefully supplied. AGE should be stated EXACTLY. If unknown, approximate. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46423

CERTIFICATE OF DEATH

E 46423

1—PLACE OF DEATH

REGISTERED NO. 26-75

CITY OF BALTIMORE: (No. 3545 5th St Brooklyn WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary C. Eichhorst

(a) RESIDENCE NO. 3545 5th St Brooklyn WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Eichhorst

6 DATE OF BIRTH (month, day, and year) June 5 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	11	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Daniel Brady

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Fahy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mr William Eichhorst

(Address) 3545 5th St Brooklyn

15 Filed [illegible] 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 3, 19 29, to May 30, 19 29,

that I last saw h[illegible] alive on May 30, 19 29

and that death occurred, on the date stated above, at 3 25 m.

The CAUSE OF DEATH* was as follows:

Carcinoma (Uterus)

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) D Whelan, M. D.

5/31, 19 29 (Address) 1279 Gilham Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Cathedral — DATE OF BURIAL June 1 19 29

20 UNDERTAKER Charles L. Stevens — ADDRESS 1501 Eutaw Pl

OF DEATH in plain terms, so that it may be properly classified. Exact statement of important. See instructions on back of certificates.

CLERK: C. H. HARRISON JONES

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46424

E 46424

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 859 Hollins ST. 18-29 WARD)

2-FULL NAME JOSEPH BENDER

(a) RESIDENCE NO. 859 Hollins ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. — mos. ds. How long in U. S., if of foreign birth? 27 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced (or) HUSBAND of / WIFE of Jaine Jurgilaitis

6 DATE OF BIRTH (month, day, and year) No. 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	—		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) No

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lithvania

PARENTS

10 NAME OF FATHER No.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithvania

12 MAIDEN NAME OF MOTHER No.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithvania

14 Informant Jaine Bender

(Address) 859 Hollins Street

15 Filed May 31 1929 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30 1929.

17 I HEREBY CERTIFY, That I attended deceased from May 15 1929. to May 30. 1929.

that I last saw him alive on May 29 1929

and that death occurred, on the date stated above, at 5 pm m.

The CAUSE OF DEATH* was as follows:

Paralysis. Broncho Pneumonia

(duration) yrs. mos. 15 ds.

CONTRIBUTORY (Secondary) Hemiplegia left side.

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical

(Signed) M. Finlinger M.D. M. D.

5/31 1929 (Address) 682 Wash Blvd -

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	June 3. 1929
20 UNDERTAKER	ADDRESS
John Greblauckas JG.	421 S Paca St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

22547 E 46425

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-001 E 46425

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST. 1-3 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adolph Gladkowski

(a) RESIDENCE NO. 2401 Foster ave ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M.	W.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Nov 27 1928

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		6	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... (State or country) Md

PARENTS

10 NAME OF FATHER Felix Gladkowski

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Poland

12 MAIDEN NAME OF MOTHER Alice Sobotka

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Poland

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 C. HAMPSON JONES, M. D.

Registrar

MAY 31 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30 1929

17 I HEREBY CERTIFY, That I attended deceased from May 18, 1929, to May 30, 1929, that I last saw him alive on May 30, 1929, and that death occurred, on the date stated above, at 5.40 A m.

The CAUSE OF DEATH* was as follows:

Typhoid fever

(duration) ..... yrs. ..... mos. 16 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) A. Tomaselli Cuneo, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	May 31 1929

20 UNDERTAKER	ADDRESS
John M Weber	4th & Chester sts

information should be carefully supplied. AGE should be stated EXACTLY. If less than one day, hours or minutes must be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-001

E 46426

CERTIFICATE OF DEATH

E 46426

1—PLACE OF DEATH

REGISTERED NO. 12-50

CITY OF BALTIMORE: (No. 2501 N. Calvert ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry E. Shepherd

(a) RESIDENCE NO. 2501 N. Calvert ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Wht	Widower

5a If married, widowed, ~~or divorced~~ HUSBAND of (or) ~~WIFE of~~ Katherine G. Goodrich

6 DATE OF BIRTH (month, day, and year) Jany 17 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86	4	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Ret. Teacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Fayetteville N.C.

PARENTS

10 NAME OF FATHER Jacob Geo. Shepherd

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Sarah J. Dobbin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C.

14 Informant Mrs. A Shepherd
(Address) 2501 N. Calvert St

15 Filed MAY 31 1929 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29 29

17 I HEREBY CERTIFY, That I attended deceased from May 27, 1929, to May 29, 1929, that I last saw h[illegible] alive on May 29, 1929 and that death occurred, on the date stated above, at 5.00 P. m.

The CAUSE OF DEATH* was as follows:

Right Bronchitis, followed by Dilated Heart

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) General Weakness

(duration) yrs. mos. 2 ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Auscultation

(Signed) E. Schmidt, M. D.

May 29, 1929 (Address) 605 N. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	June 1 1929
20 UNDERTAKER	ADDRESS
Chas. G. Black	742 W. North Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of cause important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46427

CERTIFICATE OF DEATH

E 46427

1—PLACE OF DEATH Baltimore City Hosp. REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 76-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret Hartman

(a) RESIDENCE NO. 3900 Fleet ST., 26 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Whit	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bernard Hartman

6 DATE OF BIRTH (month, day, and year) Jan 1st 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
45 46	47	5 4	29 28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Richard Hogg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Barbara Freisner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hosp. Record
(Address)

15 Filed MAY 31 1929 H. MASON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/29/29

17 I HEREBY CERTIFY, That I attended deceased from 5/6, 19 29 to 5/29, 19 29

that I last saw h.e alive on 5/29, 19 29

and that death occurred, on the date stated above, at 6 50 P. m.

The CAUSE OF DEATH* was as follows:

Hemorrhagic Pachymeningitis

Hemorrhagic encephalitis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of 5/20/29

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) L. M. Pumphrey, M. D.

5/30, 1929 (Address) Balto. City Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cem	June 1st 1929
20 UNDERTAKER D. Lilly & Sons	ADDRESS 408 S. Wolfe St

OF DEATH in plain terms, so that it may be properly classified. Each statement of fact is important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

John Herbert Robinson

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46428

CERTIFICATE OF DEATH.

123 E 46428

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 805 N Gilmore St (Ward) 11-23

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John H. Robinson

(a) RESIDENCE No. 805 N Gilmore St WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M	C	M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clara L. Robertson

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Wm. Robertson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant C. Lucy Robertson

(Address) 802 N. Gilmore St

15 Filed ..... 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28th 1924

17 I HEREBY CERTIFY, That I attended deceased from May 4th, 1924, to May 28, 1924, that I last saw him alive on May 28, 1924 and that death occurred, on the date stated above, at 2:35 P m

The CAUSE OF DEATH* was as follows:

Acute General Peritonitis and Cholangitis (Gallstones)

(duration) ? yrs. ? mos. 30 ds.

CONTRIBUTORY (Secondary) Cholangitis Gallstones & Local peritonitis (duration) ? yrs. ? mos. 30 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) G. D. Hall, M. D.

, 19 (Address) 426 E 23rd St Baltimore Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem — DATE OF BURIAL 5-31-1924

20 UNDERTAKER Byron Wright 1218 McCulloh — ADDRESS

IMPORTANT—Before Signing, Read Carefully. Exact statement of OCCUPATION should be given. CAUSE OF DEATH in plain terms, so that it may be properly classified. See instructions on back of certificates.

Spec. —1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46429

CERTIFICATE OF DEATH.

74-001

E 46429

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1109 N. Carey ST. 16-23 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amanda Fer Bloke

(a) RESIDENCE NO. 1109 N. Carey ST. ..... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown First Name -

6 DATE OF BIRTH (month, day, and year): ~~May 25~~ -1857

7 AGE: Years 78 | Months | Days | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Nurse

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Mrs Whipple Cooper

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Amanda Gilbert

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: John F. Hill

(Address): 1109 N. Carey

15 Filed ..... 19 ..... HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 28 1929

17 I HEREBY CERTIFY, That I attended deceased from May 26, 1929, to May 28, 1929, that I last saw her alive on May 27, 1929, and that death occurred, on the date stated above, at 4.30 A. m.

The CAUSE OF DEATH* was as follows:

Hemiplegia (Rt side Brain).

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage Artero Sclerosis (duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Hospital

(Signed) W. A. Bryant, M. D.

May 29, 1929 (Address) 209 Forrest Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem. — DATE OF BURIAL: May 31, 1929

20 UNDERTAKER: Finch N. Chase & Son — ADDRESS: 1400 Mahon

mation should be carefully supplied. Exact statement of OCCUPA-
CAUSE OF DEATH in plain terms, so that it may be properly classified.
TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

LEVELL

HEALTH DEPARTMENT—CITY OF BALTIMORE

46430

CERTIFICATE OF DEATH

90

E 46430

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2138 Druid Hill St., 14-20 Ward)

2-FULL NAME Hattie Lovell

(a) RESIDENCE NO. 2138 Druid Hill St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 Color or Race: Col

5 Single, Married, Widowed or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Leo Lovell

6 DATE OF BIRTH (month, day, and year): Unknown ~~May 28 1881~~

7 AGE: Years 48 | Months | Days | IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town): Va
(State or country)

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town): Unknown
(State or country)

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town): Unknown
(State or country)

14 Informant: Leo Lovell
(Address) 2138 Druid Hill

MAY 31 1929

C. HAMPSON JONES, M. D. Registrar

by Pratt

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 28 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) F. E. Kelsick, M. D.

(Address) May 28/1929 Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary — DATE OF BURIAL: May 31 1929

20 UNDERTAKER: Wm. R. C. Elliott — ADDRESS: 172 Eastern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD. Information should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46431

CERTIFICATE OF DEATH.

100-001

E 46431

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 844 ~~Hanover~~ Edmondson ST. 16-26 (WARD)

2-FULL NAME Charles Herbert Hammond

(a) RESIDENCE NO. 844 Edmondson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: ~~White~~

4 COLOR OR RACE: Blk

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept 28 1912

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
16	8	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Boy

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: John Hammond

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Mazie Talbot

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Mazie Hammond

(Address) 844 Edmondson Ave.

Filed MAY 31 1929 19 C. HAMPSON COX, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28 1929

17 I HEREBY CERTIFY, That I attended deceased from apl 15th 1929 to May 28 1929 that I last saw h. alive on May 28 1929 and that death occurred, on the date stated above, at 6.15 a m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. 1 mos 13 ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Gustav Goldman, M. D.

19 (Address) 56 N Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery

DATE OF BURIAL: May 31, 1929

20 UNDERTAKER: Mrs. Katie R. Williams

ADDRESS 322 N. Edmondson Ave

mation should be carefully supplied. AGE should be stated in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

4643a

CERTIFICATE OF DEATH

E 46432

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH 624

CITY OF BALTIMORE: (No. 624 Aull ST. 9-46 WARD)

2—FULL NAME Mary Robinson Spinner

(a) RESIDENCE NO. 624 Aull ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. — mos. — ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married~~, Widowed, or ~~Divorced~~, (write the word): Widowed

6 If married, widowed, or divorced — HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Not Known

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
71	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: George Spinner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Christina Stout.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Christina Nordt.

(Address): 624 Aull St

15 Filed MAY 31 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 30 1929

17

I HEREBY CERTIFY, That I attended deceased from Normal Life, 19 ..., to Night of death,

that I last saw h alive on May 22 1929

and that death occurred, on the date stated above, at 2.20 a m.

The CAUSE OF DEATH* was as follows:

Cancer of Liver

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) H. G. Tomlin, M. D.

May 30, 1929 (Address) 634 Gramercy Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: May 31 1929

UNDERTAKER: Henry Hoech Sons Inc — ADDRESS: 1301 E Eager St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of the conditions giving rise to the immediate cause (a, b, and c) and the underlying cause (d) should be given for each. It is important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 46433 12 30 PM

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+100-001 E 46433

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maxine Cole

(a) RESIDENCE No. Williamsport Md ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Mar 7-1929

7 AGE — Years: — Months: 2 — Days: 23 — If LESS than 1 day, hrs. or min.: 13 weeks

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work:

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Earl Cole

11 BIRTHPLACE OF FATHER (city or town) (State or country): W Va

12 MAIDEN NAME OF MOTHER: Virginia Clund

13 BIRTHPLACE OF MOTHER (city or town) (State or country): W Va

14 Informant: Records

(Address): JOHNS HOPKINS HOSPITAL

15 Filed MAY 31 1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 30 1929

17 I HEREBY CERTIFY, That I attended deceased from Mar. 29, 1929, to May 30, 1929, that I last saw her alive on May 30, 1929, and that death occurred, on the date stated above, at 2 30 P m.

The CAUSE OF DEATH* was as follows:

Hygroma of neck

(duration) yrs. 2 3/4 mos. ds.

CONTRIBUTORY (Secondary): Aspiration pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At Home (at birth)

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Phys. exam.

(Signed) H. A. Goodwin M. D.

5/30, 1929 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Fellinghaters W Va.

DATE OF BURIAL: 5/31 1929

20 UNDERTAKER: Fredk A. Cole

ADDRESS: 1616 N. Broadway

Cor.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE E 46434

E 46434

CERTIFICATE OF DEATH.

REGISTERED NO. 90

1-PLACE OF DEATH

City of BALTIMORE: (No. 327 W. 29. St. 1751 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Susie Jr. Evans

(a) RESIDENCE NO. 327. W. 29 St. 25 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Gustavus Evans

6 DATE OF BIRTH (month, day, and year) May 11 1875

7 AGE	Years	Months	Days	IF LESS than 1 day....hrs. or....min.
	54		19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) md.

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Clinton Evans.

(Address) 327 W 29 St.

15 Filed MAY 31 1929 HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-30 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) and that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Coroner M. D.

5/30 1929 (Address) 6632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Morgan Chapel Carroll Co. Date of Burial: June 1, 1929

20 UNDERTAKER: Schnorrenberg Son ADDRESS: 3615 Chestnut Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK. THIS IS A LEGAL DOCUMENT. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

Gains

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46435

CERTIFICATE OF DEATH

1284

E 46435

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 509 Wilson ST. 14-20 WARD)

2—FULL NAME Williams Matthew Gains

(a) RESIDENCE NO. 509 Wilson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	—

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 10 1928

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	3	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) no

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto Md (State or country)

PARENTS

10 NAME OF FATHER Illegitimate

11 BIRTHPLACE OF FATHER (city or town) — (State or country)

12 MAIDEN NAME OF MOTHER Carrie Gains

13 BIRTHPLACE OF MOTHER (city or town) Balto Md (State or country)

14 Informant Carrie Gains

(Address) 509 Wilson St

15 Filed MAY 31 1929 H. LAWSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/25/29

17 I HEREBY CERTIFY, That I attended deceased from 5/24/29, to 5/28/29, that I last saw h[illegible]ive on May 28 1929 and that death occurred, on the date stated above, at 6 00 P m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. R. Latham, M. D.

5/28, 1929 (Address) 1125 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	May 31 1929
20 UNDERTAKER Thomas E Kelson	ADDRESS 1506 Presstman St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46436

CERTIFICATE OF DEATH

135

E 46436

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

City of BALTIMORE: (No. Maryland Genl Hosp St.. 2865 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isaac L. Seats

(a) RESIDENCE NO. 4208 Linwall Ave St.. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married-

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~: Louise J. Seats-

6 DATE OF BIRTH (month, day, and year): Feb 5, 1850

7 AGE: Years 79 Months 3 Days 25 IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Secretary Ad

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Retired-

9 BIRTHPLACE (city or town) (State or country): New. Hampshire

PARENTS

10 NAME OF FATHER: Isaac L. Seats

11 BIRTHPLACE OF FATHER (City or town) (State or country): New Hampshire

12 MAIDEN NAME OF MOTHER: Harriet Simonds

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Mass.

14 Informant: Hosp. Records-

(Address)

15 Filed [illegible] 1929 19

[illegible] HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 30 1929

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1929, to May 30, 1929, that I last saw him alive on May 30, 1929, and that death occurred, on the date stated above, at 1:15 a m.

The CAUSE OF DEATH* was as follows:

Benign Hypertrophy of Prostate

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Uremia (Renal Suppression)

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? yes Date of May 22-

Was there an autopsy?

What test confirmed diagnosis? Clinical - Laboratory

5/30/29 (Signed) [illegible] M. D.

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem. Date of Burial: May 31 1929

20 UNDERTAKER: Wm Fletcher Sons ADDRESS: North St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46437

CERTIFICATE OF DEATH

129 E 46437

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3219 Abell Av. ST. 12-50 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ella Virginia Johnston

(a) RESIDENCE NO. 3219 Abell Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. 9 mos. 26 ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 5 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	9	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House-work

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Wm A Johnston

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mary E Carty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Mrs. Alexander Romans

(Address) 3219 Abell ave.

15 Filed MAY 31 1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31 1929

17 I HEREBY CERTIFY, That I attended deceased from May 30 1929 to May 31 1929

that I last saw h alive on May 30 1929

and that death occurred, on the date stated above, at 2.07 a m.

The CAUSE OF DEATH was as follows:

Chr. Interstitial Nephritis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry E. Wilson M. D.

, 19 (Address) 3 W. Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side fer additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount — DATE OF BURIAL June 1 1929

20 UNDERTAKER John F Denny — ADDRESS 715 Lo St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46438

CERTIFICATE OF DEATH

129

E 46438

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1012 N. Central Ave ST., 10-14 WARD)

2—FULL NAME J. Blanche Milton

(a) RESIDENCE NO. 1012 N. Central Ave ST., WARD Annapolis Md
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 days. How long in U. S., if foreign birth yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6 If married, widowed, or divorced (or) WIFE of Thomas D. Milton

6 DATE OF BIRTH (month, day, and year) Jan. 29 - 1883

7 AGE: Years 46 | Months 4 | Days 2 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Benjamine Holliday

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Julia Hardesty

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs Miller Holliday
(Address) 1012 N. Central Ave.

15 Filed ..... 19 ..... HARRISON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31 1929

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1929, to May 31, 1929, that I last saw her alive on May 30 1929 and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What lesl confirmed diagnosis

(Signed) John J. Fitch M. D.

5/31, 1929 (Address) 936 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Annis Cemetery Annapolis Md.

DATE OF BURIAL: June 2 1929

20 UNDERTAKER: Henry Hoeck Sons, Inc

ADDRESS: 1301 E Eager St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46439

CERTIFICATE OF DEATH

E 46439

1—PLACE OF DEATH

REGISTERED NO. 90

CITY OF BALTIMORE: (No. 2728 E Baltimore ST., 6-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William H Weil

(a) RESIDENCE NO. 2728 E Baltimore ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced, HUSBAND of (or) WIFE of Cora Weil

6 DATE OF BIRTH (month, day, and year) June 8. 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	11	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Continental Can Co

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Henry Weil

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Culbreson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

11 Informant Cora Weil

(Address) 2728 E Baltimore St

Filed 1-1929, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30 1929

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1929, to May 30, 1929, that I last saw h alive on May 30 1929 and that death occurred, on the date stated above, at 10:15 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary edema acute

25 minutes

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 9 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. Schiliad M. D.

May 30, 1929 (Address) 417 N. Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oakwood	6-3 1929
20 UNDERTAKER	ADDRESS
M. Cook	1217 S. Gaul St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Dr Douglas 3043 St Paul St

74-001

E 46440

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46440

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 919 N Fulton Ave ST. 16-23 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frances McDougall Stehl

(a) RESIDENCE NO. 919 N Fulton Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Gustave Stehl

6 DATE OF BIRTH (month, day, and year) Oct 10, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70	7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer At home

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Francis McDougall

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Scotland

12 MAIDEN NAME OF MOTHER Rhoda Clark

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Md

14 Informant Elizabeth McConnors

(Address) Catonsville Md

15 Filed ..... 19 HAMPSON JONES, M. D., Registrar

MAY 31 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 26th, 1929, to May 30th, 1929, that I last saw her alive on May 30th, 1929 and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) — yrs. — mos. 1 ds.

CONTRIBUTORY (Secondary) Pyelitis

(duration) — yrs. 1 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Eugene Douglas, M. D.

May 31, 1929 (Address) 3043 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

DATE OF BURIAL 6/3 19 29

20 UNDERTAKER .....

ADDRESS 21 St Paul St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 23 432
E 46441

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46441

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. (WARD) 19

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Beatrice Nelson

(a) RESIDENCE NO. Melrose School ST., WARD Reisterstown
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., If of foreign birth? yrs. 6 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	16			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md —

PARENTS

10 NAME OF FATHER: John Nelson

11 BIRTHPLACE OF FATHER (city or town) (State or country): —

12 MAIDEN NAME OF MOTHER: —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): —

14 Informant: Reads —
(Address)

Filed MAY 31 1929 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28 1929

17 I HEREBY CERTIFY, That I attended deceased from March 9 1929 to May 28 1929, that I last saw her alive on May 30 1929, and that death occurred, on the date stated above, at 1 P.M.

The CAUSE OF DEATH* was as follows:

Lymphosarcoma

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) [illegible] M. D.

19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parisfield Md. — DATE OF BURIAL 5/31/29

20 UNDERTAKER: Philip Herring — ADDRESS 2016 Orleans

B.—WRITE PLAINLY, WITH UNFADING INK. mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46442

CERTIFICATE OF DEATH

E 46442

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Balto. City Hosp. ST., 1-3 WARD)

REGISTERED NO. 161-04

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Boy Cousinski

(a) RESIDENCE NO. 1009 Binney ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 5/28/29

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Cousinski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Helen Jezior

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Hosp. Record

(Address)

15 Filed ..... 19 .....

HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/28/29

17 I HEREBY CERTIFY, That I attended deceased from 5/28, 1929, to 5/28, 1929, that I last saw him alive on 5/28, 1929 and that death occurred, on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Premature separation of placenta

(duration) yrs. mos. ½ ds.

CONTRIBUTORY (Secondary) Prematurity

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. M. Longshein, M. D.

5/30, 1929 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Municipality Hospital — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

MAY 31 1929

MAY 31 1929

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46443

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001.

E 46443

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Balto. City Hosp. ST., 1-3 WARD)

2—FULL NAME Baby Girl Consinski

(a) RESIDENCE NO. 1009 Binney ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 5/28/29

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mary land

PARENTS

10 NAME OF FATHER John Consinskis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Helen Jozwiak

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Hospital record

(Address)

15 Filed ..... 19 ..... Registrar

HAMPSON JONES, M. D.

MAY 31 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/28/29

17 I HEREBY CERTIFY, That I attended deceased from 5/28, 1929, to 5/28, 1929

that I last saw her alive on 5/28, 1929

and that death occurred, on the date stated above, at 6 1/2 a.m.

The CAUSE OF DEATH* was as follows:

Premature separation of placenta

(duration) yrs. mos. 1/2 ds.

CONTRIBUTORY (Secondary) Prematurity

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. L. Kumpkins, M. D.

5/30, 1929 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

MAY 31 1929

IMPORTANT. See instructions on back of certificates.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46444

E 46444

REGISTERED NO. 31

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST., T. B. WARD) 18-26

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Battle

(a) RESIDENCE NO. 13 S. Stockton st. ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	29			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Alfred Battle

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N.C.

14 Informant Hospital Records

(Address)

15 Filed ....., 19.... HAMPSON JONES, M. D. Registrar

MAY 31 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 26, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 13, 1929, to May 26, 1929, that I last saw h im alive on May 26, 1929 and that death occurred, on the date stated above, at 9.45 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical and lab.

(Signed) Henry C. Smith, M. D.

5-27, 19 29 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND DATE OF BURIAL MAY 31 1929

20 UNDERTAKER ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46445

CERTIFICATE OF DEATH

44 E 46445

1—PLACE OF DEATH Baltimore City Hosp. REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rufford Horsey

(a) RESIDENCE NO. 408 S. Caroline ST., ... WARD
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie Horsey

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	60 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of indostry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Robert Horsey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Hester Rosleigh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hosp. Record.
(Address)

15 ..... 19 ..... Registrar

MAY 31 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/28/29

17 I HEREBY CERTIFY, That I attended deceased from 5/8, 1929, to 5/28, 1929, that I last saw h.. alive on 5/8, 1929 and that death occurred, on the date stated above, at 12 (10) a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) ? yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Cachexia, Bronchopneumonia (duration) ..... yrs. ..... mos. 7 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of 5/15/29

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) L. U. Hampson, M. D.

5/28, 1929 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS MAY 31 1929

L. HAMPSON JONES M. D.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46446 — CERTIFICATE OF DEATH — E 46446

1—PLACE OF DEATH Baltimore City Hospitals (REGISTERED NO. 90)

CITY OF BALTIMORE: (No. 9-46 ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Bessie Turner

(a) RESIDENCE NO. 640 E. 28th ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Pennsylvania

PARENTS

10 NAME OF FATHER: James Richardson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Sarah Racket

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pennsylvania

14 Informant: Records of

(Address): Baltimore City Hospitals

15 MAY 31 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 17, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1929 to May 17, 1929, that I last saw her alive on May 17, 1929 and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis, myocardial insufficiency

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Auricular Fibrillation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No Phy. Exam

What test confirmed diagnosis?

(Signed) Warren H. Cole, M. D.

19 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: PUBLIC CEMETERY — DATE OF BURIAL 19

20 UNDERTAKER: John Meissner Sons — ADDRESS MAY 31 1929

Per Jos. L. McGrath

IMPORTANT: Before signing, make sure that it may be properly classified. Exact statement of OCCUPATION is necessary. OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is necessary. important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46447

CERTIFICATE OF DEATH

90 E 46447

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Bantalow near Edw[illegible] St. [illegible] Ward)

2-FULL NAME unknown

(a) RESIDENCE NO. unknown St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of this information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed or Divorced, (write the wurd): Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years: about 60 | Months | Days | IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED: (a) Trade, profession or particular kind of work: Think he was in employ. (b) General nature of industry, business, or establishment in which employed (or employer): Pimlico Brd & Barn & Baldy (c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address) Police Report.

15 Filed 19 HAMPSON JONES, M. D. Registrar

MAY 31 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) May 22 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. Blenk M. D.

May 24 '29 (Address) Coroner.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: C CEMETERY — DATE OF BURIAL 19

20 UNDERTAKER [illegible] — ADDRESS MAY 31 19

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46448

CERTIFICATE OF DEATH

162 E 46448

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 776 Carroll St., 21-29 Ward)

2-FULL NAME Baby Lavonis

(a) RESIDENCE NO 776 Carroll St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 27-1929

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
			2 hrs	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary Lavonis

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant
(Address)

Filed ..., 19 ... L. HAMPSON JONES, M. D. Registrar

MAY 31 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 27 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

1 Probable Congenital Atelectasis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zeller M. D.

5-31. 1929 (Address) 2739 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

THE MORGUE

MAY 31 1929

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 46449 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001

E 46449

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH WHITE'S HOSPITAL

CITY OF BALTIMORE: (No.) 1029 Madison Ave ST. 15-21 (WARD)

2-FULL NAME Baby Smith

(a) RESIDENCE No. 1554 Leslie St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years 1929 Months May Days 29 If LESS than 1 day, 1 hr. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md (State or country)

PARENTS

10 NAME OF FATHER Albert Mosley

11 BIRTHPLACE OF FATHER (city or town) N.C. (State or country)

12 MAIDEN NAME OF MOTHER Arine Smith

13 BIRTHPLACE OF MOTHER (city or town) N.C. (State or country)

14 Informant (Address)

15 C. HAMPSON JONES, M. D. Registrar

MAY 31 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-29 1929

17 I HEREBY CERTIFY, That I attended deceased from May 29, 1929, to May 29, 1929, that I last saw h alive on , 19 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

(a) Still/ Primature

About 4 and 1/2 Mo

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Congenital Atelectelis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. White, M. D.

, 19 (Address) 1029 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY

DATE OF BURIAL 19

20 UNDERTAKER Commissioner of Health.

ADDRESS

MAY 31 1929

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46450 HEALTH DEPARTMENT—CITY OF BALTIMORE E 46450

CERTIFICATE OF DEATH

31

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) Baltimore City Hospitals ST., 16-23 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mattie Carrington

(a) RESIDENCE NO. 1218 Fremont ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of John Carrington

6 DATE OF BIRTH (month, day, and year) 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	29			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town)
(State or country) Virginia

PARENTS

10 NAME OF FATHER Robert Smith

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Annie Brown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

14 Informant Hospital Records
(Address)

15 Filed ....., 19 ..... Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29, 1929.

17 I HEREBY CERTIFY, That I attended deceased from March 28, 1929, to May 29, 1929, that I last saw her alive on May 29, 1929 and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical and lab.

(Signed) Henry C. Smith, M. D.

5-29, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Portland V.A.	5-31 1929
20 UNDERTAKER Hand Easter	ADDRESS 916 Pa ave

MAY 31 1929

Medical examiner, coroner, undertaker, and informant are requested to read carefully the instructions on back of certificates, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46451

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49 ✓

E 46451

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4211 Springwood Avenue ST., 26-47 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Walter E. Snyder

(a) RESIDENCE NO. 4211 Springwood Avenue ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) January 10, 1885

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	44	4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Shirt Cutter

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore City Maryland

PARENTS

10 NAME OF FATHER Aaron Snyder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Rachel Beidelman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

14

Informant Stella Heathcote

(Address) 4211 Springwood Avenue

15

Filed ..... 19 ..... HAMPSON JONES, M. D.

Registrar

MAY 31 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30, 1929

17

I HEREBY CERTIFY, That I attended deceased from March 27, 1928, to May 30, 1929, that I last saw h... alive on May 30, 1929, and that death occurred, on the date stated above, at 5:45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Bladder (Primary)

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) General Metastasis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John D. Falk, M. D.

5/31, 1929 (Address) 936 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Camphill, Pa.	June 2 1929
20 UNDERTAKER	ADDRESS
Frederick Lazenby Son	Fullerton Md.

INFORMATION should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 46452

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46452

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Sinai Hospital

REGISTERED NO. ....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. .... ST. 7-13 WARD)

2-FULL NAME Mollie Flickinger

(a) RESIDENCE NO. .... New Windsor ST. .... Md WARD ....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred .... yrs. .... mos. 20 ds. How long in U. S., if of foreign birth? .... yrs. .... mos. .... ds.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIANS should state mation should be carefully supplied. AGE should be stated EXACTLY. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1858

7 AGE: Years 70 | Months | Days | If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Carroll Co

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Hospital Records

15 C. HAMPSON JONES, M. D. Registrar

5-31 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 31 1929

17 I HEREBY CERTIFY, That I attended deceased from May 11 1929 to May 31 1929.

that I last saw her alive on May 30 1929,

and that death occurred, on the date stated above, at 7:05 m.

The CAUSE OF DEATH was as follows:

Peri-Rectal Abscess

Diabetes Mellitus

(duration) .... yrs. .... mos .... ds.

CONTRIBUTORY (Secondary) ....

(duration) .... yrs. .... mos. .... ds.

18 Where was disease contracted if not at place of death? New Windsor, Md

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Blood Analysis

(Signed) Frederick A. Wolf M. D.

5-31 1929 (Address) Sinai Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pleasant Valley Md | DATE OF BURIAL: June 2. 29

20 UNDERTAKER: C. O. Stuart Son | ADDRESS: Taneytown Md

Spec.—2-29-28—L. F. S.—500 Bks.

E 46453

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

161-061

E 46453

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) So Balto Gen. Hosp. ST. 24-33 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lillian Mae Baker

(a) RESIDENCE NO. 614 E. Clement ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Premature

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Premature

6 DATE OF BIRTH (month, day, and year): 5/17/29

7 AGE — Years: — Months: Days: 14 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Reuben Baker

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Comanda Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore, Md

14 Informant: Hospital Records

(Address)

15 , 19 C. HAMPSON JONES, M. D. Registrar

MAY 31 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/30/29.

17 I HEREBY CERTIFY, That I attended deceased from 5/17/29, 19, to 5/30, 19 29, that I last saw her alive on 5/30, 19 29 and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity - 8-mo. child.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Unimportant.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? In utero

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical.

(Signed) F. J. Fetterolf M. D.

5/30, 1929 (Address) So Balto Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cemetery — DATE OF BURIAL: June 1 19 29

20 UNDERTAKER: Fred A Kramer — ADDRESS: 703 Hanover

IMPORTANT. See instructions on back of certificates. OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46454 90 **E 46454**

CERTIFICATE OF DEATH

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) Maryland General Hosp. St. 23-32 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Elizabeth Mae Kenthum

(a) RESIDENCE NO. 1206 S. Charles St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 53 yrs. 6 mos. 20 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, ~~widowed, or divorced~~ ~~HUSBAND of~~ (or) WIFE of: Henry Mae Kenthum

6 DATE OF BIRTH (month, day, and year): Nov - 10 - 1875

7 AGE — Years: 53 Months: 6 Days: 20 IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: H - W

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore (State or country): Md

PARENTS

10 NAME OF FATHER: John C. Beach

11 BIRTHPLACE OF FATHER (City or town): (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Anna E. Wagner

13 BIRTHPLACE OF MOTHER (city or town): (State or country): Germany

14 Informant: Hospital Record. (Address)

15 Filed 19 H. JUDSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: May 30 - 1929

17 I HEREBY CERTIFY, That I attended deceased from 5-28 1929 to 5-30 1929

that I last saw h.. alive on 5-30 1929

and that death occurred, on the date stated above, at 1.45 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 2 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary): Pulmonary Embolism.

(duration) 0 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Leipheimer M. D.

5/30 1929 (Address) Md. General Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery Date of Burial June 3 1929

20 UNDERTAKER: Fred A. Krauseden ADDRESS 703 Hanover St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state HOUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Y311929

Spec.—2-29-28—L. F. S.—500 Bks.

E 46455 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 31 E 46455

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital) (Street) (Ward) REGISTERED NO. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Louise Whittaker

(a) RESIDENCE NO. Sykesville Md. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): married

a If married, widowed, or divorced HUSBAND of (or) WIFE of: Herman Whittaker

6 DATE OF BIRTH (month, day, and year): 1909-2-15

7 AGE — Years: 70 — Months: 3 — Days: 16 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland.

10 NAME OF FATHER: D. Perkins.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland.

12 MAIDEN NAME OF MOTHER: Estelle Merrill

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland.

PARENTS

14 Informant: Herman Whittaker

(Address) R.F.D. Sykesville, Md.

15 Filed ... 19 ... HAMPSON JONES, M. D. Registrar

MAY 31 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/30/29

17 I HEREBY CERTIFY, That I attended deceased from 5/27, 1929, to 5/30, 1929, that I last saw her alive on 5/30/29, 19 and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Bilateral broncho-pneumonia (tuberculous)

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary): Pregnancy (8 mos.); Premature delivery

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Delivery Date of 5/27/29

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy-clinical

(Signed) Dulen L. Gill M. D.

5/31, 1929 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Interred Johnsville Cemetery — DATE OF BURIAL: June 2-1929.

20 UNDERTAKER: C. M. Watts — ADDRESS: Linwood, Md.

mation should be carefully supplied. ... OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46456

CERTIFICATE OF DEATH.

E 46456

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4403 Valley View Ave ST. WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Caroline Viola Hershey.

(a) RESIDENCE NO. 4403 Valley View Ave ST. ..... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry O. Hershey

6 DATE OF BIRTH (month, day, and year) Nov. 24. 1883

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
45	6	6.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Melvin Hobwood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Frederick Md.

12 MAIDEN NAME OF MOTHER Emma L. Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Henry O. Hershey
(Address) 4403 Valley View Ave

15 C. HAMPSON JONES, M. D. Registrar

MAY 31 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30 1929.

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1929. to May 29, 1929.
that I last saw h[illegible] alive on May 29, 1929.
and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 6 yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) J. C. Jones M. D.

May 1929 (Address) 1301 N Rad Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine — DATE OF BURIAL June 1 1929.

20 UNDERTAKER Wm. Mus. J. W. Teufelsdorf — ADDRESS 801 N. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. ALL information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

1.

E 46457

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

89 E 46457

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1705 Presstmann St. (Ward) 15-21

2-FULL NAME Robert J.Matthews

(a) RESIDENCE NO. 1705 Presstmann ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sophia Matthews

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	52	X	X	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chef 071

(b) General nature of industry, business, or establishment in which employed (or employer) Cooking

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Carroll Co Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Margeret J.Calvert

(Address) 1705 Presstmann St.

15 Filed ..... 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 28 1929

17

I HEREBY CERTIFY, That I attended deceased from July 6, 1928, to May 25, 1929.

that I last saw him alive on May 28, 1929,

and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos 20 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration One yrs + mos. + ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? None Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical evidence

(Signed) Charles E. Clarke, M. D.

May 29, 19 29 (Address) 3214 Pridemore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem DATE OF BURIAL June 1st 19 29

20 UNDERTAKER A. Jones ADDRESS 114 S. Gilmor St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. PHYSICIAN'S information should be carefully supplied. AGE should be stated EXACTLY. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

AY 31 1929

Spec.—2-29-28—L. F. S.—500 Bks.

E 46458

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

45

E 46458

1—PLACE OF DEATH

REGISTERED NO. 2049

CITY OF BALTIMORE: (No. 100 N University Parkway ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henrietta Gaither Banks

(a) RESIDENCE NO. 100 N University Parkway WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (write the word): Widow

5a If ~~married~~, widowed, or ~~divorced~~ ~~HUSBAND of~~ (or) WIFE of: Late? Banks

6 DATE OF BIRTH (month, day, and year): June 25 1857

7 AGE: Years 71 | Months 11 | Days 16 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Howard County Md

PARENTS

10 NAME OF FATHER: L. B. Gaither

11 BIRTHPLACE OF FATHER (city or town) (State or country): Howard County Md

12 MAIDEN NAME OF MOTHER: M. L. Banks

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Howard Co Md

14 Informant: L. B. Gaither

(Address): 100 N University Parkway

MAY 31 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 31st 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 1st, 1929, to May 31st, 1929,

that I last saw her alive on May 31st, 1929

and that death occurred, on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Rectum,

Gonorrhoea Septicaemia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Carcinoma

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? a

Did an operation precede death? a Date of —

Was there an autopsy? a

What test confirmed diagnosis? Microscopic

(Signed) J. A. Chatard, M. D.

May 31st, 1929 (Address) 130 W. Madison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	June 1st 1929
20 UNDERTAKER	ADDRESS
Geo. J. Jenkins & Son Co	1911 Eutaw St.

mation should be carefully supplied. Avoid ... OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46459

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 46459

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH Cecil Apt

CITY OF BALTIMORE: (No. 1111 N. Eutaw ST. 11-24 WARD)

2—FULL NAME Eliza Bowie Mackall

(a) RESIDENCE NO. 1111 N Eutaw ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single, Married~~ Widowed, or ~~Divorced~~, (write the word): Widow

5a If ~~married~~, widowed, or ~~divorced~~
~~HUSBAND of~~
(er) WIFE of Late Charles Mackall

6 DATE OF BIRTH (month, day, and year) May 9th 1861

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
68	-	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Colin Mackenzie

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Christiana S Mackenzie

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Mr Mackall
(Address): Cecil Apt

15 MAY 31 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) MAY 30th 1929

17 I HEREBY CERTIFY, That I attended deceased from March 20th, 1929, to May 30th, 1929, that I last saw h.e.r. alive on May 30th, 1929 and that death occurred, on the date stated above, at 7.20 P. m.

The CAUSE OF DEATH* was as follows:

CHRONIC MYOCARDITIS

(duration) 5 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) 4 weeks yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Thomas L Steele, M. D.

5/31/1929 (Address) 905 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	June 1 1929
20 UNDERTAKER	ADDRESS
Henry J Jenkins & Sons Co	Cathedral & Centre Sts

mation should be carefully supplied. AGE should be stated EXACTLY. THIS SPACE FOR USE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46460

CERTIFICATE OF DEATH.

E 46460

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Elizabeths Home ST., Chemung Ave WARD 9-47 REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sister Mary Evangelist (Nora Burke)

(a) RESIDENCE No. St Elizabeths Home ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 ? yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) February 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	73	3	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nun 065

(b) General nature of industry, business, or establishment in which employed (or employer) Sisterhood

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER unobtainable

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) "

14 Informant Convent Record (Address)

15 MAY 31 1929 ..., 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29 1929

17

I HEREBY CERTIFY, That I attended deceased from May ..., 1927 ..., to May 29 ..., 1929 ..., that I last saw h.e alive on May 27 ..., 1929 ..., and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) unknown yrs mos ds.

CONTRIBUTORY (Secondary) General Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank Lloyd M. D.

May 29, 1929 (Address) 2005 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Elizabeth Home Cem DATE OF BURIAL May 31st 1929

20 UNDERTAKER Kenny & Jenkins Sons ADDRESS McCulloh & Orchard

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46461

CERTIFICATE OF DEATH

E 46461

45

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 727 E 22nd St. 9-46 WARD)

2—FULL NAME Annie Brun

(a) RESIDENCE NO. 727 E 22nd ST., 9 WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or WIFE of): John Brun

6 DATE OF BIRTH (month, day, and year): March 29 1845

7 AGE — Years: 84 | Months: 3 | Days: 29 | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Thomas White

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Ryan

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Mrs M. Miller

(Address) 727 E 22nd st

15 [illegible] 19 [illegible] HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/29/29

17 I HEREBY CERTIFY, That I attended deceased from 5/21/29, to 5/29/29, that I last saw h[illegible] alive on 5/29/29, and that death occurred, on the date stated above, at 3.04 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Carcinoma of Rectum

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Hampson Jones, M. D.

, 19 (Address) 532 E 22nd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	June 1 19 29

20 UNDERTAKER	ADDRESS
Mary M Wiedefeld	501 E 22nd St

MAY 31 1929

mation should be carefully supplied. AGE should be stated EXACTLY. Prefixes such as Mr., Mrs., Miss, etc., are unnecessary. OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12 9 25—A Co.—200 Pks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46462

CERTIFICATE OF DEATH.

E 46462

REGISTERED NO. 31 Death

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 114 W. Chase St. 11-24 Ward)

2-FULL NAME Spencer L. Davidson

(a) RESIDENCE NO. 114 W. Chase St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 Color or Race: W.

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Hattie L. Davidson

6 DATE OF BIRTH (month, day, and year): May 27 1874

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	55	-	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Horseshoer & Editor

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Wash. D.C.

(State or country)

PARENTS

10 NAME OF FATHER: Spencer Davidson

11 BIRTHPLACE OF FATHER (city or town): Baltimore

(State or country)

12 MAIDEN NAME OF MOTHER: Laura Lee Burnell

13 BIRTHPLACE OF MOTHER (city or town): Va.

(State or country)

14 Informant: Hattie Davidson

(Address) 114 W. Chase St.

15 Filed ..... C. HAMPSON JONES, M. D. Registrar

RRH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30 1929

17

I HEREBY CERTIFY, That I attended deceased from Dec 10, 1928, to May 30, 1929, that I last saw him alive on May 30, 1929, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis -

(duration) 1 yr. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray Lab. Exam -

(Signed) Harry Mc Leary, M. D.

5-31, 1929 (Address) 3711 Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem. Date of Burial 6/1 1929

20 UNDERTAKER: J. F. Schumacher & Sons ADDRESS 1317 Eutaw St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

AY 3 1929

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46463

CERTIFICATE OF DEATH.

E 46463

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 328 N. Hilton St. 20-10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gerdrum a Kuhl

(a) RESIDENCE NO. 328 N. Hilton ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Celia M. Worrill Kuhl

6 DATE OF BIRTH (month, day, and year) Mar 16/63

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	2	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman & Sporting Leather

(b) General nature of industry, business, or establishment in which employed (or employer) goods

(c) Name of employer Balto. Leather Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Fredk Kuhl

11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't Know

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't Know

14 Informant Beatrice A. Linhart

(Address) 328 N. Hilton St.

15 Filed MAY 31 1929, 19 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29 1929

17

I HEREBY CERTIFY, That I attended deceased from May 14, 1929, to May 29, 1929, that I last saw h[illegible] alive on May 29, 1929, and that death occurred, on the date stated above, at 9.15 a. m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos 20 ds.

CONTRIBUTORY (Secondary) Coma

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? in New York State

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical test

(Signed) F. E. Smith, M. D.

5/30, 1929 (Address) 4025 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL 6/1 1929

20 UNDERTAKER William Cook — ADDRESS 1217 St Paul

B.—WRITE PLAINLY, WITH UNFADING INK. Information should be stated EXACTLY. PHYSICIANS should be careful to state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46464

CERTIFICATE OF DEATH

74-001 ✓

E 46464

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSPITALS ST. 153 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Michel (Michalak)

(a) RESIDENCE NO. 27 1/2 Elliott ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Adam

6 DATE OF BIRTH (month, day, and year)

7 AGE: 47 Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 137

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER: Michael Jacobs

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Friends

(Address)

15 Filed 19 Par Registrar C. HAMPSON JONES, M. D.

MAY 31 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5-29-29

17

I HEREBY CERTIFY, That I attended deceased from 5-27, 19 29, to 5-29, 19 29, that I last saw her alive on 5-29, 19 29 and that death occurred, on the date stated above, at 1:30 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) [illegible], M. D.

19 (Address) CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislaus Cem

DATE OF BURIAL: June 1929

20 UNDERTAKER: Stephen J. Featherowski Inc

ADDRESS: 1020 S. Kenwood Ave

mation should be carefully supplied. AGE should be stated EXACTLY. If unknown, approximate. NATURE OF OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 46465

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+84 E 46465

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. 1-9 WARD)

2-FULL NAME Harry Ettenberg

(a) RESIDENCE No. 29 Ocean Drive ST., ... WARD Brooklyn - N-Y

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 3 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1900

7 AGE — Years: 29 — Months: 4 — Days: — If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Druggist - 025

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) U-Y-

PARENTS

10 NAME OF FATHER Jacob Ettenberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Pauline

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Records - (Address) JOHNS HOPKINS HOSPITAL

15 Filed MAY 31 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31 1929

17 I HEREBY CERTIFY, That I attended deceased from May 29 1929 to May 31 1929, that I last saw him alive on May 31 1929, and that death occurred, on the date stated above, at 4.45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebello-pontine angle tumor, right

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Removal of Tumor

Did an operation precede death? Yes Date of May 31, 1929

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) I. Redleaf Tumblety M. D.

(Address) May 31 29 Johns Hopkins Hosp Balt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Brooklyn N Y — DATE OF BURIAL: 6/1/29

20 UNDERTAKER: Joseph Ahrens — ADDRESS: 224 Bway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46466

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001

E 46466

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 906 N Calvert ST., 11-15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Hamet Carrington Brown

(a) RESIDENCE NO. 906 N. Calvert ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 84 yrs. 7 mos. 3 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female.	Wht-	Widow

5a If married, widowed, or divorced (or) WIFE of Dr. Thos R Brown

6 DATE OF BIRTH (month, day, and year) Oct 28. 1844

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	-7	.3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — none

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Carrington

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Mary Perrine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant James C. Brown

(Address) Upper Falls Md

Filed JUN 1 1929, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31. 1929

17 I HEREBY CERTIFY, That I attended deceased from May 27, 1929, to May 31, 1929, that I last saw h alive on May 31, 1929 and that death occurred, on the date stated above, at 3-25 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Alc coma

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical signs.

(Signed) Thos R Brown, M. D.

, 19 (Address) 1 E Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cem — DATE OF BURIAL June 1st 19 29

20 UNDERTAKER Henry Hankins Sons — ADDRESS Pt Clonlob & Orchard Sts

mation should be carefully supplied. AGE should be stated EXACTLY. Any information OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 4646.

E 46467

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of Baltimore: (No. 125 Collins an St. 20-11 90 Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME inste d of street and number and fill out No. 18.)

2-FULL NAME Johanna Dittman

(a) RESIDENCE NO. 125 Collins St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of George Dittman

6 DATE OF BIRTH (month, day, and year) June 10- 1851

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	77	11		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Barbara Dittman
(Address) 125 Collins an

15 Filed ....., 19.... JAMESON JONES, M. D. Registrar

N 1 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/30 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to Sudden death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis.
(old age)

(duration) Sudden yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas H Brooke M. D.

5/30, 1929 (Address) 3601 3rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem

DATE OF BURIAL June 1 1929

20 UNDERTAKER John Merrick

ADDRESS 2008 Orleans

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46468

CERTIFICATE OF DEATH

90 E 46468

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 655 N. Paca St., 17-25 Ward)

2-FULL NAME Jas Shofer

(a) RESIDENCE NO. 655 N. Paca St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 Color or Race Col | 5 Single, Married, Widowed or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown.

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	64	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cutter in Box Factory
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Beckers & Son

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Gertrude Mosher
(Address) 655 N Paca

15 JUN 1 1929 . 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Regular
(Signed) [illegible] M. D.
May 30 (Address) Towson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem | DATE OF BURIAL 6/1 19

20 UNDERTAKER Clement O Kemp Sr | ADDRESS [illegible]

HAMPSON-JONES, M. D.

B—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 46469

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

37-80

E 46469

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hosp. 12-31 Ward)

2-FULL NAME Mabel Williams

(a) RESIDENCE NO. 205 W. Montgomery St Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fmal

4 Color or Race: Col

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of: No

6 DATE OF BIRTH (month, day, and year): 1918

7 AGE — Years: 11 — Months: ..... — Days: ..... — IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer): .....
(c) Name of employer: .....

9 BIRTHPLACE (city or town) Baltimore
(State or country) .....

PARENTS

10 NAME OF FATHER Westley Gough

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country) "

12 MAIDEN NAME OF MOTHER Bettie Williams

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country) "

14 Informant Bettie Williams
(Address) 205 W Montgomery

15 Filed ....., 19.....

HAMPSON JONES, Registrar

JUN 1-1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) May 30th 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Autopsy (Inquest, autopsy or inquiry) and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

General Tuberculosis

..... (duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? 205 W Montgomery

Did an operation precede death? No Date of .....

Was there an autopsy? Yes.

What test confirmed diagnosis? Yes

(Signed) 30 H. Lamb, M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Zion Cem. — DATE OF BURIAL June 1 1929

20 UNDERTAKER: A. E. Brown & Son — ADDRESS 168 W. Fayette

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 46470 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 46476

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hospital St. 14-26 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bennie Fitzgerald

(a) RESIDENCE NO. Patapsco Hotel Spruce St WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mrs Elizabeth Fitzgerald

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Clem. Fitzgerald

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Frances Richardson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant (Address) James Fitzgerald 925 Rutland Ave

15 Filed JUN 1 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31 1929

17 I HEREBY CERTIFY, That I attended deceased from May 24, 1929, to May 31, 1929, that I last saw h/ alive on May 31, 1929, and that death occurred, on the date stated above, at 4.40 A m.

The CAUSE OF DEATH was as follows:

Lobar Pneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Undetermined

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis

(Signed) B Harris M. D.

5/31/29 (Address) Provident Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Victoria Va — DATE OF BURIAL: June 1 29

20 UNDERTAKER: Mrs R. G. Elliott — ADDRESS: 925 Ashland

N.B.—WRITE PLAINLY, WITH UNFADING INK. THIS CERTIFICATE MUST BE FILLED OUT BEFORE BURIAL PERMIT IS ISSUED. INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46471

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-002

E 46471

CERTIFICATE OF DEATH

1—PLACE OF DEATH St Joseph's Hospital

REGISTERED NO. 27-48

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Caulent & Ours ST.; WARD)

2—FULL NAME Mary B. Potts

(a) RESIDENCE NO. 522 Rossiter Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 0 mos. 18 ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John W. Potts

6 DATE OF BIRTH (month, day, and year): May 13, 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	69	0	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore, Maryland

PARENTS

10 NAME OF FATHER: Edward Green

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore, Maryland

12 MAIDEN NAME OF MOTHER: Magdelene Crist

13 BIRTHPLACE OF MOTHER (city or town) (State or country): France

14 Informant: Mrs. Frances Nance

(Address): 522 Rossiter Avenue

15 Filed ..., 19 ... Registrar

JUN 1 - 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 31, 1929

17

I HEREBY CERTIFY, That I attended deceased from May 28, 1929 to May 31, 1929

that I last saw h.er alive on May 31, 1929

and that death occurred, on the date stated above, at 12.30 noon

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary): Respiratory Paralysis

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) D. Messina, M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cemetery	6/3 19 29
20 UNDERTAKER: Henry W. Mears & Son	ADDRESS: 805 N. Calvert

N. B.—WRITE PLAINLY with unfading ink. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46472

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 46472

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1259 E Fayette ST. 5-8 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Samuel Spent

(a) RESIDENCE NO. 1259 E Fayette ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should [illegible] CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): S

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan 6 1900

7 AGE — Years: 28 | Months: 11 | Days: 24 | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer): Lubmen

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): York County Va

PARENTS

10 NAME OF FATHER: Wm Spent

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Maggie Langston

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Bertha Burke

(Address) 1259 E Fayette

15 JUN 1 1929, 19

THOMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 30 29

17

I HEREBY CERTIFY, That I attended deceased from May 18, 1929, to May 30, 1929

that I last saw h[illegible]ive on May 30, 1929,

and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary): Tuberculosis

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? Physical

What test confirmed diagnosis?

(Signed) Geo. S Gill, M. D.

May 30 29 (Address) 508 Fremont St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Old Point Va.

DATE OF BURIAL: June 1 1929

20 UNDERTAKER: Jas J. G Locke

ADDRESS 2302 Jefferson Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46473

CERTIFICATE OF DEATH

38 E 46473

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 810 Leadenhall ST., 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Nelson A. Miles

(a) RESIDENCE NO. 810 Leadenhall ST., 22 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lilly B Wesley

6 DATE OF BIRTH (month, day, and year) 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Work on Boat

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant J. L. Brown Jr.
(Address) 12 Bunnell Ave.

15 C. HAMPSON JONES, M. D.
Registrar

JN 1 - 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/30/29

17 I HEREBY CERTIFY, That I attended deceased from 5/25/29, to 5/30/29, that I last saw h alive on 5/30/29 and that death occurred, on the date stated above, at 11:30 A m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

Duration # yrs. 6 mos. # ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (Bright's Disease)

Duration 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical - Microscopical

(Signed) J. Lem Bostick, M. D.

6/1, 19 29 (Address) 908 Shamp Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	June 2 1929
20 UNDERTAKER	**ADDRESS**
J. L. Brown & Son	138 W. Monument

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46474

CERTIFICATE OF DEATH.

161-01

E 46[illegible]

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital ST. 14-20 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Geil Parker

(a) RESIDENCE NO. 552 McMechen ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mns. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: black

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: New Born Infant

6 DATE OF BIRTH (month, day, and year): May 30th 1929

7 AGE: Years ..... Months ..... Days ..... If LESS than 1 day 3 hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: New Born

(b) General nature of industry, business, or establishment in which employed (or employer): Infant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): University Hospital.

PARENTS

10 NAME OF FATHER: Clyde Parker

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Georgia Bell Parker 5/30/29

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto, Md

14 Informant (Address): Georgia Bell Parker

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 30, 1929.

17

I HEREBY CERTIFY, That I attended deceased from 5-30-1929 to 5-30-1929

that I last saw h[illegible] alive on 5-30-29 19

and that death occurred, on the date stated above, at 6:50 A m.

The CAUSE OF DEATH* was as follows:

Prematurity - 24 weeks.

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature] M. D.

(Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: [illegible] LAND

DATE OF BURIAL 19

20 UNDERTAKER [illegible]

ADDRESS

JUN 1 1929

JUN 1 1929

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46475

CERTIFICATE OF DEATH

129

E 46475

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3000 Edmondson Ave. 16-70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary E. Kerwick

(a) RESIDENCE NO. 3000 Edmondson Ave. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 29 1867

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
62	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Kiern J. Kerwick

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Mary C. King

13 BIRTHPLACE OF MOTHER (city or town) Ohio
(State or country)

14 Informant Celia Kerwick
(Address) 3000 Edmondson Ave.

15 Filed ..., 19 ... C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 29, 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 1, 1928, to May 29, 1929, that I last saw her alive on May 29, 1929 and that death occurred, on the date stated above, at 12 midnight m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial nephritis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical examination

(Signed) L. A. Dally M. D., M. D.

, 19 (Address) 3517 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	June 3 1929
20 UNDERTAKER	ADDRESS
Martin Bailey & Sons	1827 W. North Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill out and sign OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

UN 1 1929

Spec.—2-29-28—L. F. S.—500 Bks.

E 46476 HEALTH DEPARTMENT—CITY OF BALTIMORE

46 E 46476

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1921 Wilkins ave ST.) 19-28 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Josephine Legnale

(a) RESIDENCE NO. 1921 Wilkins Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 21 1889

7 AGE: Years 40 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of indnstry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Pennsylvania

PARENTS

10 NAME OF FATHER: Joseph Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pennsylvania

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Donna Legnale

(Address) 1921 Wilkins Ave

15 Filed: C. HAMPSON JONES, M. D. Registrar

UN 1 - 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 5/30/29

17 I HEREBY CERTIFY, That I attended deceased from 7/1/28 19 to 5/30/29 19,

that I last saw h-r alive on 5/30/29, 19

and that death occurred, on the date stated above, at 6.40 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Uterus

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Operation St Joseph

(Signed) Bernard Levy, M. D.

5/31/1929 (Address) 904 W. Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: June 3 1929

20 UNDERTAKER: Charles H Kechner — ADDRESS: Hollins

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should [illegible] CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 46477.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46477.

1—PLACE OF DEATH

REGISTERED NO. 119

CITY OF BALTIMORE: (No.) 244 N Arlington Ave ST., (W. WARD) 16

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rebecca McConnor

(a) RESIDENCE NO. 244 N Arlington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced (write the word): Wid

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm. H. McConnor

6 DATE OF BIRTH (month, day, and year): May 30, 1844

7 AGE: Years 84 35 | Months 1 | Days 28 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Waitress

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: William Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country): Howard Co Md

12 MAIDEN NAME OF MOTHER: Elizabeth Waters

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Wm. H McConnor

(Address) 244 Arlington Ave

15 Filed ....., 19.... HAMPSON JONES, M. D. Registrar

JUN 1 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 28th 29

17 I HEREBY CERTIFY, That I attended deceased from May 19, 1929, to May 25, 1929, that I last saw h... alive on May 28, 1929 and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Pan-Rectal Abscess

(duration) yrs. mos. 28 ds.

CONTRIBUTORY (Secondary): Septic Infection

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. J. Norwood, M. D.

May 29/29 (Address) 939 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery

DATE OF BURIAL: June 1, 1929

20 UNDERTAKER: Mrs Kate R. Williams

ADDRESS 1322 Schroeder St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS ... OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION ... important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46478

CERTIFICATE OF DEATH

100-001 E 46478

REGISTERED NO.

1-PLACE OF DEATH Mercy Hospital

City of BALTIMORE: (No.) St. 4-1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Raymond Westley Grove

(a) RESIDENCE NO. 18 E. Willow Ave. St. Towson Md. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: None

6 DATE OF BIRTH (month, day, and year): May 15 1927

7 AGE — Years: 2 — Months: — Days: 16 — IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town): Towson

(State or country): Md

PARENTS

10 NAME OF FATHER: Raymond W. Grove

11 BIRTHPLACE OF FATHER (City or town): Penn.

(State or country)

12 MAIDEN NAME OF MOTHER: Martha Villers

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Penn

14 Informant: Howard B. Grove

(Address): 18 Willow Ave Towson

15 Filed JUN 2 1929 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

6-1-29

17 I HEREBY CERTIFY, That I attended deceased from 5-25-29, 19, to 6-1-29, 19, that I last saw him alive on 6-1-29, 19, and that death occurred, on the date stated above, at 5 50 p m.

The CAUSE OF DEATH* was as follows:

Von Jaksch's Anemia

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos 8 ? ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J Lupo, M. D.

(Address) Mercy Hospital 6/1/29

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Arlington Penn — Date of Burial: June 3 1929

20 UNDERTAKER: John Burns Sons — ADDRESS: Towson

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

2-5813 E 46479

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

x 49 E 46479

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Lavigne

(a) RESIDENCE No. 1544 Levis St Wash D C. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Esther Lavigne

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE: Years 46 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clothing Cutter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Israel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Bessie Siegel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

15 [illegible] C. HAMILTON JONES, M. D. Registrar

JUN 2 - 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 1 1929

17 I HEREBY CERTIFY, That I attended deceased from May 30, 1929 to June 1, 1929, that I last saw him alive on June 1, 1929, and that death occurred, on the date stated above, at 7.40 P. m.

The CAUSE OF DEATH* was as follows:

Brain tumor, Malignant

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Removal tumor Yes Date of June 1, 1929

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) I. Ridgeway Trimble M. D.

June 1929 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship Cem

DATE OF BURIAL: 6/3 1929

20 UNDERTAKER: Jack Lewis

ADDRESS 1439 E Baltimore

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46480

CERTIFICATE OF DEATH

90 E 46480

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2431 Lakeview ave ST. 13-59 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Morris A. Hartman

(a) RESIDENCE NO. 2431 Lakeview ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of: Yetta Hartman

6 DATE OF BIRTH (month, day, and year): Aug 15 1870

7 AGE: Years 55 | Months 9 | Days 16 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Merchant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Jacob Hartman

(Address) 2431 Lakeview ave

15 Filed JUN 2 - 1929 HUMPHREY JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 1 29

17 I HEREBY CERTIFY, That I attended deceased from Jan 5, 1929, to June 1, 1929, that I last saw h— alive on June 1, 1929 and that death occurred, on the date stated above, at 9.9 m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris; Cardio-Vascular disease; Hypertension

(duration) 1 yrs 5 mos. ds.

CONTRIBUTORY (Secondary): Acute Cardiac decompensation

(duration) yrs mos. 2 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Michael A. Abrams, M. D.

6/2, 1929 (Address) 360 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Cem

DATE OF BURIAL: 6/4 1929

20 UNDERTAKER: Jack Lewis

ADDRESS: 1429 E. Baltimore

N. B.—WRITE PLAINLY, WITH UNFADING INK. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 46481

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46481

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Sinai Hospital

REGISTERED NO. 124

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST. 13-59 (WARD)

2-FULL NAME Pearl Panitz

(a) RESIDENCE NO. 909 Chauncey Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Herbert Panitz

6 DATE OF BIRTH (month, day, and year) 1842

7 AGE: Years 87 | Months — | Days — | If LESS than 1 day, hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Harry Panitz (Address) Temple Gardens

15 Filed JUN 2 - 1929 JAMES S. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/1 1929

17 I HEREBY CERTIFY, That I attended deceased from 4/24, 1929, to 6/1, 1929, that I last saw h er alive on 6/1, 1929, and that death occurred, on the date stated above, at 8 p.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerotic Cardio-Vascular renal disease - ?

(duration) yrs. 5 mos 5 ds.

CONTRIBUTORY (Secondary) Hemiplegia, Lt

(duration) yrs. 1 mos. 8 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination.

(Signed) Meyer Miller, M. D.

6/1, 1929 (Address) Sinai Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Southern Cem DATE OF BURIAL 6/2 1929

20 UNDERTAKER Jack Lewis ADDRESS 1439 Eutaw St

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46482

CERTIFICATE OF DEATH

11-002

E 46482

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Balto. City Hosp. ST. 6-10 WARD)

2—FULL NAME Harry Levy

(a) RESIDENCE NO. 2178 W. Pratt ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rosa Levy

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Israel Levy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Bessie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Hospital Record

(Address)

15 Filed ..., 19... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/1/29

17 I HEREBY CERTIFY, That I attended deceased from 5/26, 1929, to 6/1, 1929, that I last saw h[illegible] alive on 6/1, 1929 and that death occurred, on the date stated above, at 3:20 p. m.

The CAUSE OF DEATH* was as follows:

Perforated duodenal ulcer

Peritonitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of 5/26/29

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) L. M. Plumpton, M. D.

6/1, 1929 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rest	6/2 1929
20 UNDERTAKER	ADDRESS
Jack Louis	1439 E. Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK. All questions should be answered. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46483

CERTIFICATE OF DEATH

123

E 46483

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital St. 15-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph H. Hachtel

(a) RESIDENCE NO. 1813 Fulton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 3 mos. 29 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Annie M. Hauner

6 DATE OF BIRTH (month, day, and year) Feby 2 - 1865

7 AGE: Years 64 | Months 3 | Days 29 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Butter & Egg Dealer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Geo. Hachtel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Elizabeth Mundorff

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Emma E. Hachtel

(Address) 1813 Fulton ave

15 Filed JUN 2 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/31/29

17 I HEREBY CERTIFY, That I attended deceased from 5/28/29, 19..., to 5/31/29, 19...

that I last saw him alive on 5/31/29, 19...

and that death occurred, on the date stated above, at 6:20 A. m.

The CAUSE OF DEATH* was as follows: Streptococcus and Staphylococcus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) cardiac decompensation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 5/29/29

Was there an autopsy? No Was there a gall bladder

What test confirmed diagnosis? Clinical

(Signed) A. Hampton, M. D.

5/31, 19 29 (Address) St Joseph's Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	June 3 1929
20 UNDERTAKER	ADDRESS
Harry W. Cullen	1912 W. North ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46484

REGISTERED NO. 185 E 46484

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Mercy Hospital. St., 15-65 (Ward)

2-FULL NAME Harry G. Giggard.

(a) RESIDENCE NO. 3701 Nortonia Rd. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married.

5a If married, HUSBAND of Effie M. Giggard.

6 DATE OF BIRTH (month, day, and year) January 31 1867.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	62	3	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Superintendant

(b) General nature of industry, business, or establishment in which employed (or employer) Maryland Lumber Co.

(c) Name of employer

9 BIRTHPLACE (city or town) Carroll Co. Md.

(State or country)

PARENTS

10 NAME OF FATHER Paul Giggard.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany.

12 MAIDEN NAME OF MOTHER Susan Essig.

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany.

14 Informant Gertrude Giggard. (daughter)

(Address) 3701 Nortonia Rd.

15 Filed ....., 19..... C. HAMPSON JONES, M. D.

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30, 1929. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Colles fracture right, Comp Colles fracture left. Infection of left arm. Accidental fall from a lumber pile.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) [illegible] M. D.

5/31. 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loraine Park Cemetery

DATE OF BURIAL June 7 1929

20 UNDERTAKER Harry W. Eden

ADDRESS 1644 W Nath Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

Spec.—2-29-28—L. F. S.—500 Bks.

E 46485 HEALTH DEPARTMENT—CITY OF BALTIMORE E 46485

CERTIFICATE OF DEATH

74-001

1—PLACE OF DEATH Balto City Hospt REGISTERED NO.

CITY OF BALTIMORE: (No. Balto 2nd ST., 9-4-6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Lochner

(a) RESIDENCE NO. 1601 E. 33rd St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 30th 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
88	88	6	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Balto City Hospt

(Address) Balto Md

15 Filed JUN 2 - 1929 19 H. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5-31-29

17 I HEREBY CERTIFY, That I attended deceased from 5-16-, 1929 to 5-31, 1929 that I last saw him alive on 5-31-, 1929 and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Terminal Bronchopneumonia (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Maurice F. Klemans, M. D.

5/31, 1929 (Address) Balto City Hospt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cem.	June 3 1929
20 UNDERTAKER Frank A. Fink	ADDRESS 910 N. Gay St

Spec.—2-29-28—L. F. S.—500 Bks.

E 46486

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-04 E 46486

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 504 Arlington Ave (Govans) (WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Nellie R. Stoekdale

(a) RESIDENCE NO. 504 Arlington Ave (Govans) WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Widow

a If married, widowed, or divorced
HUSBAND of
(or) WIFE of: Jacob F. Stoekdale

6 DATE OF BIRTH (month, day, and year): May 26 1874

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
53	10	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Frederick County Md

PARENTS

10 NAME OF FATHER: John P. Naille

11 BIRTHPLACE OF FATHER (city or town) (State or country): Frederick County Md

12 MAIDEN NAME OF MOTHER: Virginia Roberts

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Frederick County Md

14 Informant: Mrs Grace Stuller

(Address) 504 Arlington Ave

Filed JUN 2 - 1929 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 1 1929

17 I HEREBY CERTIFY, That I attended deceased from Mar. 20. 1929 to Mar. 31. 1929.

That I last saw her alive on Mar 31 1929

And that death occurred, on the date stated above, at 12.5 m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

CONTRIBUTORY (Secondary) hypertension (duration) 0 yrs. 0 mos. 0 ds.

(duration) 10 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edward Dorsey M. D.

19 (Address) Medical Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	June 3 1929
20 UNDERTAKER	ADDRESS
Jos Jacobs & Son	217 S. Ra

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46487

CERTIFICATE OF DEATH

45

E 46487

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 20-11 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine McCloskey

(a) RESIDENCE NO. 712 Lonsdale Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) Maryland

(State or country)

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (City or town) [illegible]

(State or country)

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) [illegible]

(State or country)

14 Informant Hospital Record

(Address)

15 Filed JUNE 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 5/30/29 19

17 I HEREBY CERTIFY, That I attended deceased from 5/30/29, 19..., to 5/30/29, 19..., that I last saw her alive on 5/30/29, 19..., and that death occurred, on the date stated above, at 10 00 AM m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Cecum

(duration) ... yrs. 6 mos. ... ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

(duration) ... yrs. ... mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem Date of Burial 6/3/29

20 UNDERTAKER Semple & Flanagan ADDRESS [illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—2-29-28—L. F. S.—500 Bks.

Spayd.

E 46488

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46488

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Balto City Hosp. ST., 3-5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anne Spayd

(a) RESIDENCE NO. 918 E. Lombard ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm Spayd

6 DATE OF BIRTH (month, day, and year) Unknown 1888

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Owen Huggens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kentucky

12 MAIDEN NAME OF MOTHER Fay

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Hosp. Record

(Address)

15 Filed ..... 19 .....

HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/31/29

17 I HEREBY CERTIFY, That I attended deceased from 3/6, 1929, to 6/31, 1929, that I last saw h.e alive on 6/31, 1929 and that death occurred, on the date stated above, at 2:10 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma Pharynx

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage from Carcinoma (duration) yrs. 1 mos.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) H. M. Humphrey, M. D.

6/1, 1929 (Address) Baltimore City Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem.	June 3rd 1929
20 UNDERTAKER John J. Cowan & Son	ADDRESS 901 Hollins

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JUN 2 1929

Cor.—10-10-29—A Co.—100 Bks.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E. 46489

CERTIFICATE OF DEATH

E 46489

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Cloverdale Rd between Eutaw & Mad 16

City of Baltimore: (No. Nursing Home St. 13-50 Ward)

2-FULL NAME Willard Calkins

(a) RESIDENCE 3108 Collingwood Ave Toledo Ohio
(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. 2 mos. 25 ds. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 4 1891

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	38	2	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Purchasing Agent
(b) General naturo of industry, business, or cstablishment in which employed (or employer)
(c) Name of employer Willard Cleveland Co

9 BIRTHPLACE (city or town)
(State or country) Clayton Michigan

PARENTS

10 NAME OF FATHER Elisha Calkins

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Michigan

12 MAIDEN NAME OF MOTHER Clarissa Brennan

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) N.Y.

14 Informant Miss Mary L. Watson
(Address) 92 S. Broadway

Filed JUN 2 - 1929 1929 MILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-1 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to h death on the day stated above.

The CAUSE OF DEATH* was as follows:
Strangulation, Hanging
by his neck with bath robe
Cord. (Suicide).

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

6/1 1929 (Address) 3632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Toledo Ohio	June 7 1929

20 UNDERTAKER John O Mitchell and Son ADDRESS 1900 Eutaw Place

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46490

CERTIFICATE OF DEATH

129

E 46490

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2029 Cecil Ave St., 9-18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Buckley

(a) RESIDENCE NO. 2029 Cecil Ave 9 WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Dec 1 1850

7 AGE — Years: 78 | Months: 7 | Days: 24 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Daniel Buckley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Heafey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs John Kelly

(Address): 2029 Cecil Ave

15 Filed ..... 19 ..... Registrar

JUN 2 1929

THOMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 30th 1929

17 I HEREBY CERTIFY, That I attended deceased from March 10th, 1929 to May 30th 1929 that I last saw h alive on May 30th, 1929 and that death occurred, on the date stated above, at 4.30 m.

The CAUSE OF DEATH* was as follows:

Chronic Cardio Endocarditis

" Nephritis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) — yrs. — mos. 5 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) Hibbert Brack M. D.

6/1, 1929 (Address) 1005 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: June 3 1929

20 UNDERTAKER: Mary M. Neidhold — ADDRESS: 501 E 23rd St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46491 **E 46491**

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2308 W Balto ST. 20-64 (WARD)

2-FULL NAME Mary Lait

(a) RESIDENCE NO. 2308 W Balto ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Fred Lait

6 DATE OF BIRTH (month, day, and year): Aug 15, 1872

7 AGE — Years: 56 — Months: 10 — Days: 17 — If LESS than 1 day, ... hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Patk Fitzgibbons

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Fred Lait 2308 W Balto St

15 Filed ..... 19 ..... Registrar

RAMSON JONES, M. D.

JUN 2 - 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 1 1929

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1929 to June 1, 1929.

that I last saw her alive on June 1, 1929.

and that death occurred, on the date stated above, at 10.40 A m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary): Arterio-Sclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

6/1, 1929 (Signed) Medfield M. D.

(Address) 108 N Eutaw Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: 6-4 1929

20 UNDERTAKER: H. C. Manning — ADDRESS 1136 Poplar Grove St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46492

CERTIFICATE OF DEATH.

E 46492

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1618 N.Bond St. ST. 8-17 WARD)

2-FULL NAME Margaretha Schulenberg

(a) RESIDENCE NO. 1618 N.Bond St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
female	white	widowed

5a If ~~MARRIED~~ widowed, or ~~DIVORCED~~ (or) WIFE of Julius Schulenberg

6 DATE OF BIRTH (month, day, and year) Aug 31.1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or min.
	69	10	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Philip Hiltz

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Christina Statt

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs W.A.Smith
(Address) St Paul & Chase Sts

15 Filed ..... 19.. C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 30 1929

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1922, to May 30, 1929.

that I last saw h alive on May 30, 1929

and that death occurred, on the date stated above, at 11.10P m.

The CAUSE OF DEATH* was as follows:

Multiple Neuritis
(Paralysis)

(duration) 12 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Cystitis

(duration) — yrs. 3 mos. — ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Milton P. Hall, M. D.

, 19 (Address) Resident Physician

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: 6/3/29 19

20 UNDERTAKER — ADDRESS: 424 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JUN 2 - 1929

Spec.—1-12-23—M&T—500 Blks.

Armistead H Stewart ✓ 46493.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46493

CERTIFICATE OF DEATH.

31

E 46493

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2607 Boone St., 9-46 WARD)

2-FULL NAME Ernest A Stewart

(a) RESIDENCE No. 2607 Boone St., ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	C.	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible] 1869.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER [illegible]

11 BIRTHPLACE OF FATHER (city or town) (State or country) [illegible]

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) [illegible]

14 Informant William Stewart

(Address) 2607 Boone st.

Filed ..... 19 .....

Per .....

Registrar

C. HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31 1929

17 I HEREBY CERTIFY, That I attended deceased from May 3, 1929, to May 31, 1929, that I last saw h[illegible] alive on May 31, 1929, and that death occurred, on the date stated above, at 1 50 P.M.

The CAUSE OF DEATH* was as follows:

Acute Pleurisy and Emphysema

(duration) yrs. mos 28 ds.

CONTRIBUTORY (Secondary) Pleurisy

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Clarksville

Did an operation precede death? No Date of ad

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) C. H. Hall, M. D.

, 19 (Address) 1926 Bolton St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Richmond Va — DATE OF BURIAL June 2 1929

20 UNDERTAKER Mrs. R. L. Elliott — ADDRESS 1725 Ashland Ave

C.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E46494 HEALTH DEPARTMENT—CITY OF BALTIMORE E46494

CERTIFICATE OF DEATH. 161-002

1-PLACE OF DEATH

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 1318 (ST.) Orleans (WARD) 18

2-FULL NAME Sally Cornish

(a) RESIDENCE NO. 1318 (ST.) Orleans (WARD) _____

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Black 5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 29, 1929

7 AGE Years Months Days 5 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md. (State or country)

PARENTS

10 NAME OF FATHER Larkins Cornish

11 BIRTHPLACE OF FATHER (city or town) Md. (State or country)

12 MAIDEN NAME OF MOTHER Fanny Gilburn

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country)

14 Informant Hunt Mortimer (Address) Johns Hopkins Hospital

15 Filed _____, 19__ Registrar _____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2 1929

17 I HEREBY CERTIFY, That I attended deceased from May 29, 1929, to June 2, 1929, that I last saw her alive on June 2, 1929, and that death occurred, on the date stated above, at 2.15 A.m.

The CAUSE OF DEATH* was as follows:

Intra-cranial Hemorrhage.

(duration) _____ yrs. _____ mos _____ ds.

CONTRIBUTORY (Secondary) Pneumonia.

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted if not at place of death? _____

Did an operation precede death? _____ Date of _____

Was there an autopsy? _____

What test confirmed diagnosis? _____

(Signed) Hunt Mortimer, M. D.

, 19 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ashbury Cemetery DATE OF BURIAL June 3 1929

20 UNDERTAKER Chas. H. Johnson ADDRESS 410 N. Carolina St.

MARGIN RESERVED FOR BINDING

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

GEN. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state

Spec.—1-10-21—M&T—1500 Bks.

46495

HEALTH DEPARTMENT—CITY OF BALTIMORE

46495

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1810 S Charles ST., 7332 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lucy E Fultz

(a) RESIDENCE No. 1816 S Charles ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 ~~Single, Married~~, Widowed, or ~~Divorced~~, (write the word): W

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John S Fultz

6 DATE OF BIRTH (month, day, and year): June 4 59

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
69	11	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Samuel McDonald

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant (Address): Mrs Harry Young 1210 S Schroeder St

15 Filed JUN 3 - 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 1 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1929 to June 1, 1929

that I last saw her alive on June 1, 1929

and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) Indefinite yrs. mos ds.

CONTRIBUTORY (Secondary) Ephamentosa

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. P. Campbell M. D.

June 1, 1929 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem

DATE OF BURIAL: June 3 1929

20 UNDERTAKER: W W Routson

ADDRESS 2250 N Monte

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46496

CERTIFICATE OF DEATH

74-001

E 46496

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Waldorf Hotel

City of Baltimore: (No. North Ave & Charles St. St. 12-19 Ward)

2-FULL NAME Alfred W. Schneidereith.

(a) RESIDENCE NO. Waldorf Hotel North Ave & Charles St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. ---- mos. ---- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	69	----		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Printer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Charles W. Schneidereith.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant C. Wm. Schneidereith. (nephew)
(Address) 118 Hopkins Apartments.

15 Filed ....., 19.... HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31, 1929. 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto Steinhardt, M. D.

6/3, 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	June 3 1929
20 UNDERTAKER	ADDRESS
Mr. & Mrs. John W. Teufel & Son	501 W. Fayette St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46497

E 46497

CERTIFICATE OF DEATH

31

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST. [illegible] WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Leo Goines

(a) RESIDENCE NO. 513 Walton st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1906

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Huckster

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER James Goines

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Hospital Records

(Address)

15 Filed [illegible] 19 C. HAYDON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31, 1929

17

I HEREBY CERTIFY, That I attended deceased from May 18, 1929, to May 31, 1929,

that I last saw him alive on May 31, 1929

and that death occurred, on the date stated above, at 5.45 P. m.

The CAUSE OF DEATH* was as follows:

Cancer of pneumonia

[illegible] (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Henry C. Smith, M. D.

6-31, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	6-3 1929
20 UNDERTAKER	ADDRESS 916
Daniel Easton	Dame

Cor.—12-9-25—A Co.—200 Bks.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46498

CERTIFICATE OF DEATH.

11-25

E 46498

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Sinai Hospital St.) Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Gwendolyn Walters van Hulsteyn

(a) RESIDENCE NO. St James Apartments St. Ward

(Usual place of abode) Charles & Centre Sts. (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Joan C van Hulsteyn

6 DATE OF BIRTH (month, day, and year) June 9th 1906

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	22	11	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) Pittsburgh, Pa. 6/3/29

(State or country)

PARENTS

10 NAME OF FATHER Thomas James Walters

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Wales

12 MAIDEN NAME OF MOTHER Adelaide Keeler

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) New York

14 Informant Mrs. Adelaide Walters

(Address) 3928 Ridgewood Ave.

Filed JUN 3 1929 19 HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Bichloride Mercury Poisoning.
Partial Autopsy- no operation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. S. Mc Collum M. D.
(Coroner)

(Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rock Creek Cem. Wash, D.C. Date of Burial 6/4 1929

20 UNDERTAKER Wm J Tschudi & Son ADDRESS Baltimore

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46499

REGISTERED NO. E 46499

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 1749 E. North Ave St. 15-21 (Ward)

2-FULL NAME Luther E. Inge

(a) RESIDENCE NO. 1749 E. North Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Katie Bordley Inge

6 DATE OF BIRTH (month, day, and year) Dec 28/1852

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	76	5	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Norfolk, Va.
(State or country)

PARENTS

10 NAME OF FATHER Capt. Wm. Inge

11 BIRTHPLACE OF FATHER (city or town) Norfolk, Va.
(State or country)

12 MAIDEN NAME OF MOTHER Fannie Brushwood.

13 BIRTHPLACE OF MOTHER (city or town) Va.
(State or country)

14 Informant Mrs. Katie Bordley Inge
(Address) 1749 E. North Ave

15 Filed ....., 19.... C. HARRISON JONES, M. D.
Per ..... Registrar

JUN 5 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, Autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or Inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Bloom, M. D.

6/2/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem — DATE OF BURIAL June 1 1929

20 UNDERTAKER J. J. Tucker, Sons — ADDRESS L. Pratt

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

Spec.—1-12-23—M&T—500 Bks.

E 46500 HEALTH DEPARTMENT—CITY

CERTIFICATE OF DEATH

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1604 W Franklin St. 19-2 (Ward)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Henry Waters

(a) RESIDENCE NO. 1604 W Franklin St., Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divoreed, (write the word)
Male	Colored	married

5a If married, widowed, or divoreed
HUSBAND of (or) WIFE of Sara Waters

6 DATE OF BIRTH (month, day, and year) Dec 22 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	46	5	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Penn Sylvania Railroad Howard Co Md

9 BIRTHPLACE (city or town) (State or country) Howard Co Md

PARENTS

10 NAME OF FATHER Thomas Waters

11 BIRTHPLACE OF FATHER (city or town) (State or country) Howard Co.

12 MAIDEN NAME OF MOTHER Mary Ellen June

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Sara Waters
(Address) 1604 Franklin St

Filed JUN 3 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31 1929

17 I HEREBY CERTIFY, That I attended deceased from May 28, 1929, to May 31, 1929, that I last saw h alive on May 31, 1929, and that death occurred, on the date stated above, at 6:30 A. m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? P.R.R. Tunnel

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical - Microscopical

(Signed) Stanley W. H. Wright, M. D.

June 1, 1929 (Address) 1209 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel, Md — DATE OF BURIAL June 3, 1929

20 UNDERTAKER Mrs. Katie R. Williams — ADDRESS 322 N. Schroeder St.

Spec.—2-29-28—L. F. S.—500 Blks.

...ARTMENT—CITY OF BALTIMORE

E 46501

CERTIFICATE OF DEATH

161-001

E 46501

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 3603 5th St. Brooklyn 25-75 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Eunice Miller

(a) RESIDENCE NO. 3603 5th ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Femal	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 22 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Brooklyn Md

PARENTS

10 NAME OF FATHER Henry Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Brooklyn Md

12 MAIDEN NAME OF MOTHER Maggie Grimes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Brooklyn Md

14 Informant Mrs Henry Miller

(Address) 3603 5th st.

15 Filed JUN 3 1929 19 By C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1 1929

17 I HEREBY CERTIFY, That I attended deceased from May 22, 1929, to June 1st 1929, that I last saw h[illegible] alive on May 31st 1929 and that death occurred, on the date stated above, at 11.15 a m.

The CAUSE OF DEATH* was as follows:

Inanition

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Immaturity (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? P. Examination

(Signed) Robert W. Johnson M. D.

June 1st 1929 (Address) Brooklyn

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — DATE OF BURIAL June 3 1929

20 UNDERTAKER Johnt Denny — ADDRESS 715 Light St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Corr—10-10-29—A Co.—100 Bks.

E 46502

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46502

CERTIFICATE OF DEATH

24-34

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Port Covington. St. 24 Ward)

2-FULL NAME Mary L. Beall.

(a) RESIDENCE NO. Port Covington. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 8 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) February 6, 1923

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	6	8	26 25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Richard H. Beall.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Prince George Co. Md.

12 MAIDEN NAME OF MOTHER Margaret C. Smoot.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland.

14 Informant Richard H. Beall. (father)
(Address) Port Covington.

15 Filed JUN 3 - 1929 19 HAMPSON JONES M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1, 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning.

Accidental fall from a barge while at play.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Leinhardt, M. D.

6/3, 1929 (Address) 1017 St. Charles st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill

DATE OF BURIAL 6/3 1929

20 UNDERTAKER Margaret E. Flynn

ADDRESS 1422 Light

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46503 — E 46503

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS — REGISTERED NO.

CITY OF BALTIMORE: (No. [illegible] ST., 5-C WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harry Wilson

(a) RESIDENCE NO. 1307 E Lexington ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
42				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Abraham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Minnie Howard

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Relative
(Address)

15 Filed, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-1-29

17 I HEREBY CERTIFY, That I attended deceased from 5-23-29, to 6-1-29,
that I last saw h[illegible] alive on 6-1-29
and that death occurred, on the date stated above, at 8:30 A. m.

The CAUSE OF DEATH* was as follows:

Cardiac Insufficiency
Myocardial Insufficiency
Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Syphilitic Aortitis
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no What test confirmed diagnosis? Physical & + Ray

(Signed) Warren M. McLean, M. D.
19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cem	June 4th 1929

20 UNDERTAKER Brown & Wright ADDRESS 1218 N. Caldery St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46504

CERTIFICATE OF DEATH

129 E 46504

1—PLACE OF DEATH University Hosp. REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 22-30 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Carrie Bouley

(a) RESIDENCE NO. 538 Burgundy St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1866

7 AGE: 64 Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Cambridge Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Cambridge Md.

12 MAIDEN NAME OF MOTHER: Lizzie Bolly

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Cambridge Md.

14 Informant: Carrie Easter

(Address) 538 Burgundy St

15 Filed ..... 19 ..... HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 30th/29.

17 I HEREBY CERTIFY, That I attended deceased from May 28th, 1929, to May 30th, 1929, that I last saw h alive on May 30th 1929 and that death occurred, on the date stated above, at 2.30 A m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage
arteriosclerosis, hypertension
Chronic nephritis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): Pulmonary edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? 538 Burgundy St.

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy.

(Signed) C. G. Wards, M. D.

19 (Address) Univ. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Albion Cemtry

DATE OF BURIAL: 5/31 1929

20 UNDERTAKER: Walter B. Spriggs

ADDRESS: 139 W. Pratt St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46505

CERTIFICATE OF DEATH

101-001

E 46505

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 414 Lynndale St ST. 12-51 WARD)

2—FULL NAME Annie L. Burke.

(a) RESIDENCE NO. 500 W 28th St ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph L. Burke.

6 DATE OF BIRTH (month, day, and year) March 15 1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37	2	16.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md

PARENTS

10 NAME OF FATHER Samuel Young

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Louisa B. Ferguson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Joseph L. Burke

(Address) 414 Lynndale St.

15 Filed ..... 19 ..... Registrar

HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 29, 1929 to June 1, 1929

that I last saw h[illegible] alive on June 1, 1929

and that death occurred, on the date stated above, at 7:30 a.m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

Sudden

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. L. Richardson M. D.

June 3, 1929 (Address) 1170 W. 25 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	June 3, 1929
20 UNDERTAKER	ADDRESS
Ehrenwerth Son	300 Aisquith

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46506

CERTIFICATE OF DEATH.

90 E 46506

1-PLACE OF DEATH West Baltimore General 30-18 REGISTERED NO.

CITY OF BALTIMORE: (NO. ST. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Benjamin Claiwens (Chwens)

(a) RESIDENCE NO. 3410 Holmes Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anetta Chwens

6 DATE OF BIRTH (month, day, and year) 1869 1859

7 AGE: Years 63 | Months — | Days — | If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Watch Maker

(b) General nature of industry, business, or establishment in which employed (or employer): 639

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant Mrs. L. Lasher

(Address) 447 N. Ballo St

15 Filed JUN 3 1929 H. HARRISON JONES, Registrar. Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 30, 1929, to June 2, 1929.

that I last saw him alive on June 2, 1929

and that death occurred, on the date stated above, at 5:35 P.M.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Jack J. Singer, M. D.

6/2, 1929 (Address) West Balto. General.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mehren Hebrew Rem DATE OF BURIAL 6/3 1929

20 UNDERTAKER Jack Lewis ADDRESS 1439 E Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21—M&T—1500 Bks.

E 46507

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46507

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Franklin Square Hospital — REGISTERED NO. 15-58 69

CITY OF BALTIMORE: (No. —) ST., — WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mason B. Davis

(a) RESIDENCE NO. 3124 (Usual place of abode) ST., Fenwick Ave WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 30 - 1927

7 AGE: Years 2 | Months 4 | Days 3 | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Harry M Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Rose N. Goldsmith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Harry M. Davis

(Address) 3124 Fenwick Ave

15 Filed JUN 3 1929, 19 — [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/3 1929

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1929, to June 3, 1929.

that I last saw h[illegible] alive on June 3, 1929

and that death occurred, on the date stated above, at 7:45 A m.

The CAUSE OF DEATH* was as follows:

Haemophilia

(duration) 2 yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Arthur Patterson, M. D.

6/3/29 (Address) Franklin Sq Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Northern Memorial Park — DATE OF BURIAL: 6-3-1929

20 UNDERTAKER: Jack Lewis, 1439 E Balto — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—2-29-28—L. F. S.—500 Bks.

E 46508

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129

E 46508

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1354 N. Potomac ST. 6-11 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Samuel Beardmore

(a) RESIDENCE NO. 1354 N. Potomac ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): M

a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah Malcolm Beardmore

6 DATE OF BIRTH (month, day, and year): Dec 7, 1859

7 AGE — Years: 69 | Months: 5 | Days: 24 | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Printer

(b) General nature of industry, business, or establishment in which employed (or employer): (Retired)

(c) Name of employer: Bennett & Pottery

9 BIRTHPLACE (city or town) (State or country): England

PARENTS

10 NAME OF FATHER: Samuel Beardmore

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Sarah Malcolm

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Scotland

14 Informant: Mrs Robt Mc Clintock

(Address) 1354 N. Potomac St.

15 Filed JUN 3 - 1929 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 1, 29

17 I HEREBY CERTIFY, That I attended deceased from May 1, 29 to June 1, 29

that I last saw h alive on May 31, 29,

and that death occurred, on the date stated above, at 7 A.M.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

6

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clin

(Signed) J. Lowe Insley, M. D.

(Address) 2738 E. Balt.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: June 4, 1929

20 UNDERTAKER: John F. Inman

ADDRESS: 3000 E. Balt St.

N. B. WRITE PLAINLY, WITH CARBON PAPER. THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46509

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001

E 46509

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 6 W. Barney St ST. 22-30 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William P. Lyon

(a) RESIDENCE NO. 6 W. Barney St ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. 5 mos. 6 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 25 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min..
	44	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Andrew Lyon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Wilhelmina Durham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Snyder
(Address) 6 W. Barney St

15 Filed ..... 19 .....

HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-1-29

17 I HEREBY CERTIFY, That I attended deceased from May 25, 1929, to June 1, 1929, that I last saw h[illegible] alive on June 1, 1929, and that death occurred, on the date stated above, at 10:20 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

CONTRIBUTORY (Secondary) Erysipelas (duration) yrs. mos. 8 ds.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. H. Campbell M. D.

June 2, 1929 (Address) 1644 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery

DATE OF BURIAL 6/4 1929

20 UNDERTAKER L. Few McCully

ADDRESS 1308 Font

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46510

CERTIFICATE OF DEATH

129

E 46510

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 2621 E Oliver ST., 8-16 WARD)

2—FULL NAME Charles Rossman Sr.

(a) RESIDENCE NO. 2621 E Oliver ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced, (or) WIFE of: Margt E Rossman

6 DATE OF BIRTH (month, day, and year): Dec 22 1853

7 AGE — Years: 75 — Months: 5 — Days: 9 — If LESS than 1 day, hrs. or min.: 10

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cabinet Maker

(b) General nature of industry, business, or establishment in which employed (or employer): 014

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10 NAME OF FATHER: Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant: Harry F. Rossman

(Address): 2827 Brendon Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6-1-29

17 I HEREBY CERTIFY, That I attended deceased from June 20 1929 to 6-1 1929

that I last saw him alive on 6-1 29

and that death occurred, on the date stated above, at 4:30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Arteriosclerosis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary): Chronic Nephritis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Findings

(Signed) Ned Langfeld M. D.

6-1 1929 (Address) 800 N Rutland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Immanuel Cem. — DATE OF BURIAL: 6-4 1929

20 UNDERTAKER: Wm Chas G Robke — ADDRESS: 2327 Edmondson.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Before the CAUSE OF DEATH is mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write the CAUSE important. See instructions on back of certificate. in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is

JUN 2 - 1929

HARRISON-JONES, M

Spec.—12-9-25—A Co.—200 Blks.

E 46511 HEALTH DEPARTMENT—CITY OF BALTIMORE 129 **E 46511**

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 2728 (Street) Georgetown Rd (Ward) 12

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna F. Blacket

(a) RESIDENCE NO. 2728 (Usual place of abode) Georgetown Road Ward

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George H. Blacket

6 DATE OF BIRTH (month, day, and year): July 17-1867

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or .... min.
	61	10	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Balto, (State or country) Md

PARENTS

10 NAME OF FATHER Conrad Kapraun

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant: Joseph F. Blacket (Address) 2728 Georgetown Road

15 Filed ....., 19.... Registrar

CAMERON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1 1929

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1928, to June 1, 1929, that I last saw her alive on June 1, 1929, and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis. Chronic interstitial Nephritis. Glaucoma Meningitis. due to ruptures

(duration) ..... yr. last ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Robert C Hunt, M. D.

5/29/29 (Address) 2510 Wilkens ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery Date of Burial June 4 1929

20 UNDERTAKER: George L. Schwab ADDRESS: Fairfield, Ave

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

UN3-1929

Spec.—2-29-28—L. F. S.—500 Bks.

E 46512

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46511

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3710 (ST.) Overview Rd (WARD) 45-58 161-00

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Fortus Cascio

(a) RESIDENCE NO. 3710 (ST.) Overview Rd (WARD)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Wh.	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 31, 29

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Sam'l Cascio

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Rose Cascio

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Rose Cascio

(Address) 3710 Overview Rd

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31, 29

17

I HEREBY CERTIFY, That I attended deceased from May 30, 1929, to May 31, 1929, that I last saw her alive on May 31, 1929 and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Fortus (5 mos. Gestation)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) F. L. Dadaglicco M. D.

19 (Address) 1300 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL S HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER —

ADDRESS —

JUN 3 1929

N. B.—WRITE PLAINLY, WITH UNFADING INK. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46513

CERTIFICATE OF DEATH

E 46513

1—PLACE OF DEATH University Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. ST, 24-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry Kemp

(a) RESIDENCE NO. 1408, E. Fort Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

a If married, widowed, or divorced, HUSBAND of (or) WIFE of Theresa Kemp

6 DATE OF BIRTH (month, day, and year) Dec 29. 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	53	5	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Post-office clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER anthony Kemp

11 BIRTHPLACE OF FATHER (city or town) (State or country) germany

12 MAIDEN NAME OF MOTHER Lyzetta Stockman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) germany

11 Informant Mrs. Kemp (wife)

(Address) 1408 E Fort ave

15 Filed JUN 3 1929, 19

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1, 1929

17

I HEREBY CERTIFY, That I attended deceased from May 20, 1929, to June 1, 1929, that I last saw h im alive on June 1, 1929 and that death occurred, on the date stated above, at 10.55 p.m.

The CAUSE OF DEATH* was as follows:

Cholecystitis
Cholelithiasis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Infarct of lung

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of 5/27/29

Was there an autopsy? no

What test confirmed diagnosis? clinical and operative

(Signed) G.K. Jülich, M. D.

6/1/, 1929 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem.

DATE OF BURIAL June 4 1929

20 UNDERTAKER Margaret A. Flynn

ADDRESS 1422 Light St

IMPORTANT: This certificate should be carefully filled in with ink, and every question answered. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 46514

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46514

CERTIFICATE OF DEATH

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 812 N. Caroline St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Bettie L. Mallery

(a) RESIDENCE NO. 812 N. Caroline St WARD Washington D. C.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	C.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) September 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Louisa Co. (State or country) Va.

PARENTS

10 NAME OF FATHER Levi Mallery

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER June Scott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Hattie Gaines
(Address) 812 N. Carolines St

15 Filed ....., 19.... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1st 1929

17 I HEREBY CERTIFY, That I attended deceased from May 24, 1929, to June 1st, 1929, that I last saw h.... alive on May 31, 1929 and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder and Intestines (Anus)

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) R. T. Jenny, M. D.

June 3 1929 (Address) 1424 E Thousand St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Washington D. C.	June 3, 1929
20 UNDERTAKER Mrs. P. C. Elliott	ADDRESS 1925 Ashland Ave

N. B.—WHITE PAPER, BLACK INK. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

JUN 3 - 1929 C. HAMPSON JONES, M. D.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46515 104-002 **E 46515**

CERTIFICATE OF DEATH

REGISTERED NO.

I—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 206 Mc. Mechen St. WARD 14-20)

2—FULL NAME Elizabeth Poulson

(a) RESIDENCE NO. 206 Mc. Mechen ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Nov. 12. 1849

7 AGE — Years: 79 Months: 6 Days: 20 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: not any
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Alex. W. Poulson
11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md
12 MAIDEN NAME OF MOTHER: Sarah J.
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: W. M. McCormick
(Address) 3908 N. Charles St

15 Filed JUN 3 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 2. 1929

17 I HEREBY CERTIFY, That I attended deceased from May 27. 1929. to June 2. 1929.
that I last saw h[illegible] alive on June 2. 1929
and that death occurred, on the date stated above, at [illegible] m.
The CAUSE OF DEATH* was as follows:

"Septic Sore Throat"
Staphylococcic infection.
(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) —
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Culture throat —

(Signed) A. F. Robinson, M. D.
6/3. 1929 (Address) 836 Park ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Green Mount — DATE OF BURIAL: June 4 1929

20 UNDERTAKER: John O. Mitchell Sons — ADDRESS: 1900 Eutaw Place

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should ... OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION ... important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 46516

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 100-08

E 46516

1-PLACE OF DEATH The Church Home & Infirmary

REGISTERED NO._____

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

City of BALTIMORE: (No. _____ St. 629 Ward)

2-FULL NAME Miss Fannie Grumbacher

(a) RESIDENCE NO. York Penna St. _____ Ward _____

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. mos 5 ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 6-1882

7 AGE: Years 47 Months 2 Days 27 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Trenton N. J.

PARENTS

10 NAME OF FATHER: Samuel Grumbacher

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER: Carolina Rauch

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) New York City

14 Informant: C. A. Stasch Son

(Address) York Pa

15 Filed _____ 19___ C. HAMPSON JONES, M. D. Registrar

UN 3 - 1929

By RKP

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 28, 1929, to June 3, 1929, that I last saw h[illegible] alive on June 3, 1929, and that death occurred, on the date stated above, at 1.55 P. m.

The CAUSE OF DEATH* was as follows:

Abscess in Right Inguinal Region

(duration) ___ yrs. 3 mos. ___ ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) ___ yrs. ___ mos. 2 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of May 29, 1929

Incision & drainage of abscess.

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Fred R. Landon, M. D.

, 19 (Address) The Church Home & Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Prospect Hill York Pa

Date of Burial 6/4 1929

20 UNDERTAKER: Wm Cook

ADDRESS 1217 St Paul

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item in this information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46517

CERTIFICATE OF DEATH

E 46517

118-202

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Johns Hopkins Hospital St., 1-3 Ward)

2-FULL NAME Edith Louise Dorn

(a) RESIDENCE NO. 907 S. Binney St., Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 26/28

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	5	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General naturo of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) .....
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Geo. E. Dorn

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Catherine Connelly

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) New York City.

14 Informant Geo. E. Dorn
(Address) 907 S. Binney St.

15 Filed ..... 19 ..... HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2/9 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Intussesception (intestinal)

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? .....

Did an operation precede death? yes Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) J S McCoen, M. D.

6/3/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mathias Cemetery

DATE OF BURIAL June 4 1929

20 UNDERTAKER Lilly & Zeiler Inc.

ADDRESS 403 S. Wolfe

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JUN 3 1929

Spec.—2-29-28—L. F. S.—500 Bks.

E 46518

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

29 E 46518

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1920 N Patterson Pk Ave ST. 15 WARD)

2—FULL NAME John Mick

(a) RESIDENCE NO. 1020 N Patterson Pk. ST. Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Elizabeth Mick

6 DATE OF BIRTH (month, day, and year) Oct. 25-1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	6	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Wm Mick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Barbara Nagle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Elizabeth Mick

(Address) 1020 N Patterson Pk Ave

15 Filed JUN 3 - 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1st 1929.

17 I HEREBY CERTIFY, That I attended deceased from May 4th, 1929, to June 1st, 1929, that I last saw h[illegible] alive on June 1st, 1929, and that death occurred, on the date stated above, at 2300 m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Cardio Vascular Renal disease, Arteriosclerosis

(duration) yrs. / mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical diagnosis

(Signed) W. S. Interhouse, M. D.

6/2 1929 (Address) 1901 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Lawn Cem	June 4 1929
20 UNDERTAKER	ADDRESS
Geo M. Trill & Son	811 W Wolfe

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is ... important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46519

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St.) 18-29 (Ward)

2-FULL NAME Edward F. Eiltz

(a) RESIDENCE NO. 872 W. Lombard St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 56 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

100-02

E 46519

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Eiltz

6 DATE OF BIRTH (month, day, and year) Jan 28, 1873

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
56	4	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER John Eiltz

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Holland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Elizabeth Eiltz
(Address) 872 W. Lombard St

15 Filed ..... 19.... THOMPSON JONES, M. D. Registrar

JUN 3 - 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31 — 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

1 Broncho-Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 872 W. Lombard St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zeller M. D.

6/1, 1929 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem.

DATE OF BURIAL 6/4 1929

20 UNDERTAKER J. H. Cox

ADDRESS 1217 E. Fort Ave

IN. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46520

CERTIFICATE OF DEATH.

E 46520

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital (St.) 5-12 (WARD)

2-FULL NAME Carrie Aelick

(a) RESIDENCE NO. 1702 Harmon Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced: HUSBAND of or) WIFE of Andrew J. Aelick

6 DATE OF BIRTH (month, day, and year): Sept. 29, 1893

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
35	8	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Antony Pontoni

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Katherine Feiter

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Andrew J. Aelick 1702 Harmon Ave

15 Filed JUN 3 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6-1 1929

17

I HEREBY CERTIFY, That I attended deceased from 5-31, 1929, to 6-1, 1929

that I last saw h. alive on 6-1, 1929

and that death occurred, on the date stated above, at 7:50 a. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Status Epilepticus

Pregnancy (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) Joseph G. Laitkatis M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cem

DATE OF BURIAL: 6-4 1929

20 UNDERTAKER: D. M. Cook

ADDRESS: 2174 Frank

Spec.—1-10-21—M&T—1500 Bks.

E 46521

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 46521

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 134 S. Schroeder St. WARD) 16-29

2-FULL NAME Mary V. Lawler.

(a) RESIDENCE No. 134 S. Schroeder St. ST., .WARD

(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White.	Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles E. Lawler.

6 DATE OF BIRTH (month, day, and year) June 26. 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
72	72	11	5	
73				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Easton, Md.

PARENTS

10 NAME OF FATHER Saml Jones.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kent Co. Md.

12 MAIDEN NAME OF MOTHER Savage.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown.

14 Informant Anna Bell Walters, (Address) 134 S. Schroeder St

15 JUN 3 - 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1. 1929.

17 I HEREBY CERTIFY, That I attended deceased from Jan. 1. 1929. to June 1. 1929.

that I last saw her alive on June 1. 1929.

and that death occurred, on the date stated above, at 11:40 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Int. Nephritis.

(duration) — yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) Chronic Endocarditis.

(duration) — yrs. 6 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Microscopic Exam.

(Signed) Thos. Carlton, M. D.

6/4, 1929 (Address) 888 N. Longwood St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkton Md.

DATE OF BURIAL 6/5/29

20 UNDERTAKER Richard W. Meyer 1620

ADDRESS Ashburton

I. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item on this mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46522

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46522

CERTIFICATE OF DEATH

11-00

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 412 S Eaton ST. 26-37 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Faverina Mae Huber

(a) RESIDENCE NO. 412 S Eaton ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): April 13 1926

7 AGE: Years 3 | Months 2 | Days | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto.

PARENTS

10 NAME OF FATHER: William Huber

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto

12 MAIDEN NAME OF MOTHER: Emily Kushing

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mother

(Address): 412 S Eaton St

15 Filed JUN 3 - 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 2 1929

17 I HEREBY CERTIFY, That I attended deceased from 4/18/29, 19..., to 6/2, 1929, that I last saw her alive on 6/2, 1929, and that death occurred, on the date stated above, at 11 a.m.

The CAUSE OF DEATH* was as follows:

Influenza, Pleurisy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Exhaustion

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) [illegible] M. D.

6/3, 1929 (Address) 633 S. Conkling

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn

DATE OF BURIAL: June 4 1929

20 UNDERTAKER: M. W. E. Dept. Inc.

ADDRESS: 321 Conway

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46523

CERTIFICATE OF DEATH.

146 E 46523

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hosp (St.) 700 (WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sara Beck.

(a) RESIDENCE No. 355 Southhill ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Roland Beck

6 DATE OF BIRTH (month, day, and year): Oct 1 1897

7 AGE: Years 31 | Months 8 | Days | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Andrew Snyder

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa.

12 MAIDEN NAME OF MOTHER: Anna Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): New York.

14 Informant (Address): Roland Beck. 355 Fort Hill ave.

15 Filed JUN 4 - 1929 19

C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 1 1929

17

I HEREBY CERTIFY, That I attended deceased from May 29, 1929, to June 1, 1929,

that I last saw her alive on June 1, 1929,

and that death occurred, on the date stated above, at 8 10 0 m.

The CAUSE OF DEATH* was as follows:

Puerperal pericholonitis and Sepsis Lacerata

(duration) ... yrs. mos. 7 ds.

CONTRIBUTORY (Secondary): Peritonitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Nicholas D Bonelli M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery

DATE OF BURIAL: Jun 5 1929

20 UNDERTAKER: Geo. F. Roth

ADDRESS: 1735 Harford ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46524

E 46524
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
City of Baltimore: (No. Enroute St. Joseph Hospital St., 22-30 Ward)

2-FULL NAME George Stank or Stenikwicz

(a) RESIDENCE NO. 218 S. Eutaw St., Ward
(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	50			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Former Tailor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Lithuania

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Lithuania

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Lithuania

14 Informant Mary Karalus
(Address) 218 S. Eutaw St

15 Filed ....., 19 .... HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:
Pistol Shot wound in left chest
(Suicide Belair Rd & Parkside Dr.)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? By

What test confirmed diagnosis?

(Signed) ..... M. D.

6/4/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	June 5 1929
20 UNDERTAKER	ADDRESS
John Gudauskas	423 S. Paca

Cor.—10-10-29—A Co.—100 Bks.

E 46525

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

113 E 46525

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 532 N. Central Ave St. 10-14 Ward)

2-FULL NAME Milton Purnell

(a) RESIDENCE NO. 532 N. Central Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	B	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 8/28

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
		9	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Earl Purnell

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Sadie Harman

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto., Md.

14 Informant Earl Purnell
(Address) 532 N. Central Ave

15 Filed ..., 19.. WILLIAM J. JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
(Inquest, autopsy or inquiry) find that said deceased came to h.. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gastro-Intestinal Indigestion

(duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY
(Secondary)

(duration) ..yrs. ..mos. ..ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature] M. D.

6/4/29 (Address) 303 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary June 4 1929

20 UNDERTAKER Mrs R A Elliott ADDRESS 1725 Eutaw Pl

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 46526 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1901

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1812 D.H. ST. 14-20 WARD)

REGISTERED NO. E 46526

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sylvia Heath

(a) RESIDENCE NO. 1812 Dund Hill ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1858

7 AGE 71 Years Months Days If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wool

(b) General nature of industry, business, or establishment in which employed (or employer) Woolen Mill

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Southampton Va

PARENTS

10 NAME OF FATHER Richmond

11 BIRTHPLACE OF FATHER (city or town) (State or country) Richmond

12 MAIDEN NAME OF MOTHER Richmond

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Richmond

14 Informant Daniel Heath (Address) 1812 Dund Hill

15 Filed JUN 4 - 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/1 1929

17 I HEREBY CERTIFY, That I attended deceased from 5/20, 1929, to 6/1, 1929, that I last saw h alive on 6/1, 1929, and that death occurred, on the date stated above, at 2:20 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

Pneumonia

(duration) yrs mos 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Hampton Heath, M. D.

6, 1929 (Address) 2134 Druid Hill

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount DATE OF BURIAL 6/4/29

20 UNDERTAKER Daniel Donnelly ADDRESS 1138 Bridge

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46527.

CERTIFICATE OF DEATH

E 46527.

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3002 (St.) Chesterfield Ave (Ward) 25-40

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Dora Stevens

(a) RESIDENCE NO. 3002 (Usual place of abode) Chesterfield Ave WARD

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: George Stevens

6 DATE OF BIRTH (month, day, and year): January 17, 1842

7 AGE: Years 87 | Months 4 | Days 16 | If LESS than 1 day, hrs. or min. 15

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: John Dittman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Dora Schleir

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs. Barbara Weitzel

(Address) 3002 Chesterfield Ave

15 Filed JUN 4 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 2, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 2, 1925, to June 2, 1929, that I last saw her alive on June 2, 1929 and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis and Hemiplegia

(duration) 4 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical symptoms

(Signed) Albert S. Singewald M. D.

6/3/1929 (Address) 1613 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Trinity Cemetery — DATE OF BURIAL: June 5 1929

20 UNDERTAKER: John Merrick — ADDRESS: 200 Orleans St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 46528

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46528

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL (ST.) 9-46 (WARD)

REGISTERED NO. 13

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cecelia Taylor

(a) RESIDENCE NO. 518 S Amne St (ST.) Balto md (WARD)
(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W.	S.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 025

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ... 000

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Felix

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Anna Scracka

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant ... Records
(Address) ...

15 Filed JUN 4 - 1929 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1 1929

17

I HEREBY CERTIFY, That I attended deceased from May 29, 1929, to June 1, 1929, that I last saw her alive on June 1, 1929, and that death occurred, on the date stated above, at 10 45 P m.

The CAUSE OF DEATH* was as follows:

- broncho - pneumonia
- abscesses of Kidney

2 wks.
(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) H. C. Longcope, M. D.

6/2, 1929 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary DATE OF BURIAL: June 4 1929

20 UNDERTAKER: H. W. Ozazedski ADDRESS: 1930 Eastern Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46529

CERTIFICATE OF DEATH

129 E 46529

REGISTERED NO.

1-PLACE OF DEATH Md. General Hosp. Balto

City of BALTIMORE: (No.) St. (Ward) 70-69

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Wiedey

(a) RESIDENCE NO. 324 Stinson St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~~Life~~ yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Catherine Wiedey.

6 DATE OF BIRTH (month, day, and year) March 11, 1855

7 AGE: Years 74 Months 2 Days 21 IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 039

(b) General nature of industry, business, or establishment in which employed (or employer) Electrician.

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.

(State or country)

PARENTS

10 NAME OF FATHER Charles A. Wiedey.

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Germany.

12 MAIDEN NAME OF MOTHER Wilhelmina Lemkuhl

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany.

14 Informant Mrs. Catherine Wiedey.

(Address) 324 Stinson St

15 Filed JUN 4 1929 C. HAMILTON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2 1929

17 I HEREBY CERTIFY, That I attended deceased from May 16, 1929, to June 2, 1929, that I last saw h. alive on June 2, 1929, and that death occurred, on the date stated above, at 1.30 a. m.

The CAUSE OF DEATH* was as follows:

Gas Gangrene Left Leg

Thrombosis left Popliteal Art.

Chronic Nephritis

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Acute Suppurative Cystitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 17, 1929

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) H. L. Kempelmacher, M. D.

6/2, 19 29 (Address) Md. General Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery. Date of Burial June 4-1929.

20 UNDERTAKER Charles J. Schwab. ADDRESS 505 N. Monroe St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46530

E 46530

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 3855 Roland Ave ST., 13 WARD)

2—FULL NAME Dr. Millard F. Barnes

(a) RESIDENCE NO. 3855 Roland Ave ST., 13 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 49 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nettie M. Barnes

6 DATE OF BIRTH (month, day, and year) Nov. 26-1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Pharmacist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Joseph Barnes

11 BIRTHPLACE OF FATHER (city or town) Maryland
(State or country)

12 MAIDEN NAME OF MOTHER Mary

13 BIRTHPLACE OF MOTHER (city or town) Maryland
(State or country)

14 Informant Mrs. Nettie M. Barnes

(Address) 3855 Roland Ave.

15 Filed JUN 4 1929, 19 C. HAMPSON JONES, M. D. Registrar

By R. E. K.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3 1929.

17 I HEREBY CERTIFY, That I attended deceased from Jan 9, 1929, to June 3, 1929, that I last saw him alive on June 3, 1929 and that death occurred, on the date stated above, at 6 H. m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Arteria Sclerosis Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) Millard F. Barnes, M. D.

, 19 (Address) 4037 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	June 5 19 29.

20 UNDERTAKER Horace F. Burgee ADDRESS 3401 Falls Road

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

225888

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46531

CERTIFICATE OF DEATH.

X 101-601

E 46531

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 19-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charlotte Carter

(a) RESIDENCE NO. Elkridge Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 21, 1928

7 AGE Years: Months 9 10 Days 13

If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Walter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Ida Marshall

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUN 4 - 1929 G. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1929

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1929, to June 4, 1929,

that I last saw her alive on June 4, 1929,

and that death occurred, on the date stated above, at 1.15 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Secondary Anemia

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Elkridge, Md.

DATE OF BURIAL: June 4, 1929

20 UNDERTAKER: E. Leroy Stauffer Inc.

ADDRESS: 125 E. North Ave.

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 46532

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46532

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Bolt Eye Ear & Throat Hsp.

CITY OF BALTIMORE: (No.) 1214 Eutaw Place (St.) (Ward) 11-24

2-FULL NAME George Hubbard Edgar

(a) RESIDENCE. No. Cambridge Md St., Ward.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred yrs mos 7 ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
M	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 11 - 1914

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	14	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cambridge Md.

PARENTS

10 NAME OF FATHER Harry Earl Edgar

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cambridge Md.

12 MAIDEN NAME OF MOTHER Lillian Leigh

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Glendeale Co. Va.

14 Informant (Address) Harry Earl Edgar Cambridge Md.

15 Filed ..... 19 ..... WILLIAM H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/4/ 1929

17 I HEREBY CERTIFY, That I attended deceased from 6/3/ 1929 to 6/4/ 1929 that I last saw h[illegible] live on 6/4/ 1929 and that death occurred, on the date stated above, at 10.05 Am

The CAUSE OF DEATH* was as follows:

Spinal meningitis 10.05 Am

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) Several yrs. mos. ds.

18 Where was disease contracted if not at place of death? at Cambridge Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory & Clinical

(Signed) Francis W January, M. D.

, 19 (Address) 405 N Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cambridge Md	June 1929
20 UNDERTAKER	ADDRESS
[illegible]	[illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JUN 4 1929

Spec—12-23-21—E.B.R.S.—400 Bks.

E 46533

E 46533 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

159-002

1-PLACE OF DEATH

City of BALTIMORE: (No. 622 S Linwood St., 1 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Ernest Sunderland

(a) Residence No. 622 Linwood ave St., Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 3 1929

7-AGE. ..... yrs. ..... mos. 1 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country). Balto Md

PARENTS.

10-NAME OF FATHER. James Ernest Sunderland

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Baltimore

12-MAIDEN NAME OF MOTHER. Margaret Tallutto

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Balto

14-INFORMANT. James Ernest Sunderland

(Address) 622 S Linwood ave

15-Filed JUN 4 - 1929 H. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 4 - 1929

17-I HEREBY CERTIFY, That I attended deceased from June 3 1929 to June 4 1929

that I last saw him alive on June 3 1929

and that death occurred, on the date stated above, at 7.30 a.m.

The CAUSE OF DEATH* was as follows:

Congenital Malformation Cardiac

5 mos Duration (Duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (Duration) ..... yrs. ..... mos. ..... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis?.....

(Signed) H Peterson M D M. D.

6/4, 1929 (Address) 1305 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. New Cathedral DATE OF BURIAL. June 4, 1929

20-UNDERTAKER. Frank V. Pepersone ADDRESS 2614 E. Balto St

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46534

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

124

E 46534

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 14 N Arlington St ST., 6-9 (WARD)

2—FULL NAME Rita Cooper

(a) RESIDENCE NO. 14 N Arlington ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	single

a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 15 1906

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	8	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Geo. Boone

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Jane Dixon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Estella Brown (sister)

(Address) 2214 McCulloh St

15 Filed 19

C. HARRISON JONES, M. D.

Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2 1929

17 I HEREBY CERTIFY, That I attended deceased from May 23, 1929, to June 2, 1929

that I last saw her alive on June 1, 1929

and that death occurred, on the date stated above, at 5.30 A'm.

The CAUSE OF DEATH* was as follows:

Acute Chole cystitis
& Marked Jaundice

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Jaundice

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R J Gerking, M. D.

6/3, 1929 (Address) 1729 E Monument st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	June 5 1929
20 UNDERTAKER Thomas E. Kelson	ADDRESS 1503 Pressman St

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 46535

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 46535

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 37 E. Hughes St. St. 22-33 Ward)

2-FULL NAME John Roche. (C)

(a) RESIDENCE NO. 37 E. Hughes St. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. ---- mos. ---- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Do not know

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	60	----------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Crisfield, Md.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Police Report. S.D.
(Address)

15 Filed ....., 19.....

JUN 4 - 1929

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 20, 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the Heart.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto H. Kleinschmidt, M. D.

6/8 · 1929 (Address) 1017 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS JUN 4 - 1929

Commissioner of Health

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 46536

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46536

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 518 Brunwillow St. 5-8 Ward)

2-FULL NAME. Melvina Umphrey

(a) RESIDENCE. No. 518 Brunwillow St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	Col.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 23 1913

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	15	7	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Balto. City.

PARENTS

10 NAME OF FATHER Wm J. Umphrey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Memphis, Tenn.

12 MAIDEN NAME OF MOTHER Anna Cottman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. City

14 Informant Anna Umphrey
(Address) 518 Brunwillow

15 Filed . 19 C. HAMILTON JONES, M. D. Registrar
By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 28- 1929, to June 2- 1929.
that I last saw h[illegible] alive on June 1- 1929.
and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Organic heart disease
(mitral incompetency)

(duration) — yrs. 4 mos. — ds.

CONTRIBUTORY (Secondary) None known
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical exam.

(Signed) Chas. J. Keller, M. D.

6/3, 1929 (Address) 2226 W. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Peter's Cemetery — DATE OF BURIAL: June 5, 1929

20 UNDERTAKER: Mrs. Katie R. Williams — ADDRESS 3227 Schroeder St

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46537

E 46537.

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. Baltimore City Hospitals — COUNTY (OR WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Robert Garside

(a) RESIDENCE NO. 1213 N. Potomac ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mrs. Hilda Garside

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE: Years 42 | Months | Days | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Court Stenog.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Roberte Garside

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ella P. Young

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Hilda Garside

(Address) Middletown, Md.

15 JUN 4 - 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-2-29

17 I HEREBY CERTIFY, That I attended deceased from 3-11-, 1929, to 6-2, 1929, that I last saw h[illegible] alive on 6-2, 1929 and that death occurred, on the date stated above, at 7:20 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Date of

Was there an autopsy? Lab & Clinical

What test confirmed diagnosis?

(Signed) Henry Smith, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: 6/5/1929

20 UNDERTAKER: John G. Connelly — ADDRESS: Essex Md

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CA... OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is ... important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46538

CERTIFICATE OF DEATH.

90 E 46538

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 416 S. Furrow St. W-69 Ward)

2-FULL NAME William Mews

(a) RESIDENCE NO. 416 S. Furrow St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Martha Mews

6 DATE OF BIRTH (month, day, and year): Aug. 8th 1850

7 AGE: Years 78 | Months 9 | Days 26 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED:
(a) Trade, profession or particular kind of work: Tool Dresser
(b) General nature of industry, business, or establishment in which employed (or employer): in Hair Factory for
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany.

14 Informant: Mrs. Martha Mews
(Address): 416 S. Furrow St.

15 [illegible], 19[illegible] C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 3rd. 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 25, 1926, to June 3, 1929, that I last saw h.. alive on June 2, 1929, and that death occurred, on the date stated above, at 10 20 a. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration), ... yrs. ..... mos. 14 ds.

CONTRIBUTORY (Secondary) Arteria Sclerosis

(duration) 3 yrs. ..... mos. ..... ds.

18 Where was disease contracted? Home

If not at place of death?

Did an operation precede death? No Date of .....

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Dawson Kelly M. D.

6/4, 1929 (Address) 2021 N. Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery Date of Burial June 6 1929

20 UNDERTAKER: George L. Schwartz & Son ADDRESS 1101 Eutaw Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MN 4-1929

Spec.—2-29-28—L. F. S.—500 Bks.

E 46539

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46539

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3117 Virginia ave (WARD) 27-56 REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lloyd M. Miller

(a) RESIDENCE NO. 3117 Virginia ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna J. Miller

6 DATE OF BIRTH (month, day, and year): Oct 2 1871

7 AGE: Years 57 | Months 7 | Days 29 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Asst Engineer

(b) General nature of industry, business, or establishment in which employed (or employer): C. & P. Telephone Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Penn.

PARENTS

10 NAME OF FATHER: Wilton Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Penn

12 MAIDEN NAME OF MOTHER: Marion Holtzman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs. Stackman

(Address) 3117 Virginia ave.

15 Filed JUN 4 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 1 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb 10 1929 to June 1 1929

that I last saw h in alive on June 1 1929

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Uraemia

CONTRIBUTORY (Secondary) Myocardial degeneration (duration) yrs. 2 mos. ds. Arterio-sclerosis, Interstitial nephritis

18 Where was disease contracted if not at place of death? (duration) 3 yrs. mos. ds.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory

(Signed) A. T. Rice M. D.

June 3 1929 (Address) 24 E Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: June 5 1929

20 UNDERTAKER: John A. Moran — ADDRESS: 3000 E Balto St

UN 4 - 1929

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 46540

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 E 46540

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1022 Valley (S.) 10-14 (WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter Davey

(a) RESIDENCE NO. 1022 Valley ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Davey (nee Mills)

6 DATE OF BIRTH (month, day, and year) Dec. 13, 1857

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
69	5	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work General laboring

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer City

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER James Davey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Mc. Gilmon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Mary Davey Wife
(Address) 1022 Valley St

15 Filed JUN 4 1929, 19 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3. 1929

17 I HEREBY CERTIFY, That I attended deceased from 6/3/28 to 6/3/29, 19, that I last saw him alive on 6/2/29, 19, and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma (Laryngeal)

(duration) 1 yr. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? ✓

(Signed) H. W. Sanders, M. D.

6/4/29, 19 (Address) 321 E 25

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL June 7, 1929

20 UNDERTAKER Elmer W. Conklin — ADDRESS 924 E. Eager St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

Mattison

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46541

CERTIFICATE OF DEATH

E 46541

1-PLACE OF DEATH

City of Baltimore: (No. 3330 Fairfield Rd. St. 25-76 90 Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Madison.(O)

(a) RESIDENCE NO. 3330 Fairfield Rd. St., Fairfield Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	Widow.

5a If [illegible], widowed, [illegible] (or) WIFE of James E, Madison.(O)

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	50	----------		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) .....

(State or country) South Carolina.

PARENTS

10 NAME OF FATHER Samuel Arnold.(C)

11 BIRTHPLACE OF FATHER (city or town) .....

(State or country) South Carolina.

12 MAIDEN NAME OF MOTHER Fannie Arnold.(O)

13 BIRTHPLACE OF MOTHER (city or town) .....

(State or country) South Carolina.

14 Informant Sater Walker.(C) daughter.

(Address) 3330 Fairfield Rd. Fairfield.

15 Filed JUN 4 - 1929 C. HAMPSON JONES, M. D. Registrar

Per .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1, 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

Acute dilatation of the Heart.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? .....

Did an operation precede death? No. Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto Reinhardt, M. D.

6/4, 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Calvary Cem	June 6 1929

20 UNDERTAKER Robert F. Williams ADDRESS 1515 Mc Culloh St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 46542 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 46542

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 960 Frankstown Rd ST. 28-16 WARD)

2-FULL NAME John Henry Dansenger

(a) RESIDENCE NO. 960 Frankstown Rd ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Caroline Dansenger

6 DATE OF BIRTH (month, day, and year) Feb 23 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	76	3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER George Dansenger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Ann Knodle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Charles Dansenger (Address) 960 Frankstown Rd

15 Filed ... 19 ... Registrar C. HAMPSON JONES, M. D.

Date JUN 4 - 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3 1929

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1929, to June 3, 1929, that I last saw h— alive on June 2, 1929, and that death occurred, on the date stated above, at 1130 a m.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(duration) 1 yrs. no mos 1 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) R. O. Gladden M. D.

June 3, 1929 (Address) Lutherville

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westview Cemetery DATE OF BURIAL June 5th 1929

UNDERTAKER A. D. Wescott ADDRESS 155 N. Dulton St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46543

E 46543

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO. 101

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 1027 Eutaw St. (ST.) 11-24 (WARD)

2-FULL NAME Henrietta Thompson

(a) RESIDENCE NO. 1027 Eutaw St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George

6 DATE OF BIRTH (month, day, and year) [illegible] 3, 187[illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant George Thompson

(Address) 1027 N. Eutaw

15 Filed ..... 19 C. HAMPSON JONES, M. D. Registrar

UN4-1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3 1929

17 I HEREBY CERTIFY, That I attended deceased from May 30, 1929, to June 3, 1929, that I last saw her alive on June 3, 1929 and that death occurred, on the date stated above, at 2:50 p m

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? no Date of no

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) G. L. Hall, M. D.

, 19 (Address) 426 E 23rd St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bush Creek Cockeysville — DATE OF BURIAL: 6/6 1929

20 UNDERTAKER: Mrs. Ida E. Holland — ADDRESS: 1163 Druid

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 6-9-19 H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46544

CERTIFICATE OF DEATH.

E 46544

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: No. 3304 Clifton Ave (ST.) (WARD)

2-FULL NAME. Emma Florence Peters

(a) RESIDENCE. No. 3304 Clifton Ave ST., WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: Geo. D. Peters

6 DATE OF BIRTH (month, day, and year): Sept 2 - 1864.

7 AGE: Years 64 Months 9 Days 4 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Hw

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Pa

PARENTS

10 NAME OF FATHER: John Sheeler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa.

12 MAIDEN NAME OF MOTHER: Emma Shuler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa.

14 Informant (Address): Geo D Peters 3304 Clifton ave

15 Filed 1929 HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 4 1929

17

I HEREBY CERTIFY, That I attended deceased from Sept 30, 1928 to June 4, 1929.

that I last saw her alive on June 3, 1929.

and that death occurred, on the date stated above, at 6.15 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma breast

(duration) yrs. 8 mos. 5 ds.

CONTRIBUTORY (Secondary) Toxaemia Metastasis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 1928

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dead Bowden, M. D.

6/4 1929 (Address) 1517 E. North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Spring City Penna DATE OF BURIAL: June 6, 1929

20 UNDERTAKER: Chas. G. Black ADDRESS: 742 W. Saratoga

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JUN 4 - 1929

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 46545 HEALTH DEPARTMENT—CITY OF BALTIMORE E 46545

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 4000 Groveland ave. ST. 15-63 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margery V McGonigle.

(a) RESIDENCE. NO. 4000 Groveland ave ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph P. McGonigle

6 DATE OF BIRTH (month, day, and year) — — 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Alexander Newman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Elizabeth Gallagher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Canada

11 Informant Jos. P. McGonigle

(Address) 4000 Groveland Ave

Filed JUN 4 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3 1929

17 I HEREBY CERTIFY, That I attended deceased from April 17, 1929, to June 3, 1929, that I last saw h[illegible] alive on June 2, 1929, and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

① Chronic endocarditis
② Edema of extremities, ascites.

(duration) 10 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Acute myocarditis

(duration) 0 yrs. 0 mos. 0 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy? no.

What test confirmed diagnosis? Examination

(Signed) Chas. S. Nentoth. M. D.

19 (Address) 1730 Linden ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 6/5 1929

20 UNDERTAKER J. F. Bailey & Sons — ADDRESS 1318 Eutaw Pl

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 46546

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46546

CERTIFICATE OF DEATH.

49

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hospital (ST.) 30-27 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliz. Boyle

(a) RESIDENCE NO. 2002 N. Fayette [redacted] ST., ... WARD ...

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 90; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Annie Connor

(Address) 817 E Madison St

15 Filed UN4-1929 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6-3-1929

17

I HEREBY CERTIFY, That I attended deceased from 5-27, 1929, to 6-3, 1929,

that I last saw her alive on 6-3, 1929,

and that death occurred, on the date stated above, at 4 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Splenic Flexure

(duration) 1 yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) Nicholas P Bonello M. D.

, 1929 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: 6/5/29

UNDERTAKER: Temple Farley Funeral Home

ADDRESS: Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 46547

REGISTERED NO. E 46547

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH The Church Home & Infirmary

City of BALTIMORE: (No. 669 St. Ward)

2-FULL NAME Mr. John J. Dunning

(a) RESIDENCE NO. 26 Allegheny ave Lowson St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 7 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	white	married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth W Collings Dunning

6 DATE OF BIRTH (month, day, and year) May 7 1863

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	66	—	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Express Transfer

(b) General nature of industry, business, or establishment in which employed (or employer) Express

(c) Name of employer Maryland

9 BIRTHPLACE (city or town)

(State or country) Maryland

PARENTS

10 NAME OF FATHER John Dunnigan

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Arabella Jackson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland

14 Informant Elizabeth W. C. Dunnigan

(Address) 26 Allegheny ave Towson

Filed JUN 5 1929 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 13, 1928, to June 4, 1929, that I last saw him alive on June 4, 1929, and that death occurred, on the date stated above, at 7.05 P. m.

The CAUSE OF DEATH* was as follows:

Empyema, left chest, secondary to Carcinoma of descending Colon and Diaphragm.

(duration) yrs. 6 mos. 22 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. ½ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Jan 2, 1929

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) Fred K. Landon, M. D.

, 19 (Address) The Church Home & Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Prospect Hill cemetery Lowson Date of Burial June 6 1929

20 UNDERTAKER Chas. S. Black ADDRESS 742 W. North ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46548

CERTIFICATE OF DEATH

E 46548

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. 16-27 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Amanda Carter

(a) RESIDENCE NO. 623 N. Mount ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records of

(Address) Baltimore City Hospitals

15 Filed JUN 5 1929, 19 HARRY JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) May 31, 1929

17 I HEREBY CERTIFY, That I attended deceased from January 4, 19 29 to May 31, 19 29

that I last saw her alive on May 31, 19 29

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis. Chronic.

Myocardial Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr. Bronchitis

Hypertension (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) Harris W. Wilkins, M. D.

, 19 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	June 5 1929

20 UNDERTAKER	ADDRESS
Virginia A. Brooks	1463 N. Carey

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.-7-17-26-A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46549

CERTIFICATE OF DEATH

161-001

E 46549

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Md. Gen. Hosp. St. 15-21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Kendall #1.

(a) RESIDENCE NO. 1908 W. North Ave. St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 5-31-29

7 AGE Years Months Days IF LESS than 1 day 3 hrs. or 40 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant.

(b) General nature of industry, business, or establishment in which employed (or employer):

(r) Name of employer

9 BIRTHPLACE (city or town) Md. Gen. Hosp.

(State or country) Balto, Md.

PARENTS

10 NAME OF FATHER Ozman Kendall

11 BIRTHPLACE OF FATHER (City or town) Centreville

(State or country) Md.

12 MAIDEN NAME OF MOTHER Viola Clark

13 BIRTHPLACE OF MOTHER (city or town) Balto,

(State or country) Md.

14 Informant (Hosp. Records.)

(Address)

15 Filed JUN 5 1929 HAMILTON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-1-29. 19

17 I HEREBY CERTIFY, That I attended deceased from 9.40 P.M. 5-31, 1929, to 1.20 A.M. 6-1-1929, that I last saw him alive on 6-1-, 1929, and that death occurred, on the date stated above, at 1.20 A.m.

The CAUSE OF DEATH* was as follows:

Prematurity. (7 mos)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Placenta previa of mother (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? at home.

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? Clinical & Laboratory.

(Signed) Ozman Kendall M.D.

19 (Address) 1908 W. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hopt — Date of Burial 19

20 UNDERTAKER — ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 46550

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001

E 46550

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. Ind. Gen. Hosp. St. 15-21 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Kendall #2

(a) RESIDENCE NO. 1908 W. Mosher Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 5-31-29.

7 AGE Years Months Days IF LESS than 1 day 7 hrs. 55 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant. Ind

(b) General nature of industry, business, or establishment in which employed (or employer): Infant

(c) Name of employer

9 BIRTHPLACE (city or town): Balto,

(State or country): Md.

PARENTS

10 NAME OF FATHER Ozmon Kendall

11 BIRTHPLACE OF FATHER (City or town): Centerville

(State or country): Md.

12 MAIDEN NAME OF MOTHER Viola Clark

13 BIRTHPLACE OF MOTHER (city or town): Balto,

(State or country): Md.

14 Informant: Hosp. Records.

(Address)

15 Filed JUN 5 1929 C. HAMPSON LEE, M. D. Registrar

by _____

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: 6-1-29.

17 I HEREBY CERTIFY, That I attended deceased from 9:50 PM. 5-31-1929, to 2:25 AM 6-1-1929.

that I last saw him alive on 6-1-29. 19

and that death occurred, on the date stated above, at 2:25 a. m.

The CAUSE OF DEATH* was as follows:

Prematurity (7 mos)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Placenta praevia of mother

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & laboratory

(Signed) Ozmon Kendall M. D.

(Address) 19

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hopk

Date of Burial 19

20 UNDERTAKER

ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

E 46551

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

161-001

E 46551

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 9-18 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Dill

(a) RESIDENCE NO. 731 E. Hoffman St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 6 4 29

7 AGE Years Months Days IF LESS than 1 day 6 hrs. min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md

PARENTS

10 NAME OF FATHER Fred W Dill

11 BIRTHPLACE OF FATHER (City or town) Balto Md (State or country)

12 MAIDEN NAME OF MOTHER Mary A Madigan

13 BIRTHPLACE OF MOTHER (city or town) Balto Md (State or country)

14 Informant Mrs Mary A. Dill (Address) 731 E. Hoffman St

Filed JUN 5 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/5/29 19

17 I HEREBY CERTIFY, That I attended deceased from 6/4/29, 19, to 6/5/29, 19, that I last saw h[illegible] alive on 6/5/29, 19, and that death occurred, on the date stated above, at 3 22 a.m. p.m.

The CAUSE OF DEATH* was as follows:

Prematnre Birth

(duration) yrs. 6 mos. Bestat. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) F. S. Winstead, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery Date of Burial 6/5 1929

20 UNDERTAKER George J Ruth ADDRESS 1735 Harford Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46552

CERTIFICATE OF DEATH

E 46552

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST., 6-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Florence Johnson

(a) RESIDENCE NO. 209 N. Bond st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Elizah Johnson

6 DATE OF BIRTH (month, day, and year) 1905

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	24			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Abraham Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Francis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records

(Address)

15 Filed JUNE 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 5, 1929, to June 1, 1929, that I last saw her alive on June 1, 1929, and that death occurred, on the date stated above, at 8:45 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical and Lab.

(Signed) Henry C Smith, M. D.

6-1-, 19 29 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Calvary Cemetery — DATE OF BURIAL: June 4 1929

20 UNDERTAKER: E. Bryan — ADDRESS 1631 Orleans St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46553

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46553

REGISTERED NO. 1-24-29

1—PLACE OF DEATH

CITY OF BALTIMORE, (No.) 530 Dolphin ST. (or) WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles N. Brown

(a) RESIDENCE NO. 530 Dolphin ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lula Brown

6 DATE OF BIRTH (month, day, and year): May-10-1861

7 AGE: Years 68 | Months | Days 23 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Janitor

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Lula Brown

(Address) 530 Dolphin St.

15 Filed JUN 5 1929 H. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 3rd 1929

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1929 to June 3, 1929 that I last saw h[illegible] alive on June 3rd, 1929 and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Cardio Vascular Renal Disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Unspecified Senility (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) [signature], M. D.

6-5-1929 (Address) 1222 Druid Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL 6-6 1929

20 UNDERTAKER: Samuel D Douglas — ADDRESS 878 N Bond

BEFORE signing be carefully supplied. ALL blanks to be filled EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46554

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46554

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 665 W Fairmount Ave ST., W 25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Walter J Curtis

(a) RESIDENCE NO. 665 W Fairmount Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 5- 1907

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clothier

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Walter J. Curtis

11 BIRTHPLACE OF FATHER (city or town) Balto Md (State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant W. J Curtis

(Address) 64 St Josephs Ter

15 Filed ..... 1929 ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3 29

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1929, to June 3 1929,

that I last saw h alive on June 3 1929

and that death occurred, on the date stated above, at 2 20/60 m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

CONTRIBUTORY (Secondary) Pulmonary Edema (duration) yrs. 3 mos. ds.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Jos T Moorwood, M. D.

, 19 (Address) 609 Fairmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary Cem

DATE OF BURIAL 6-8 1929

20 UNDERTAKER Jas H. Skinner

ADDRESS 1820 E. Madison St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JUN 5 1929 C. HAMILTON JONES, M. D. Registrar

Spec.—1-10-21—M&T—1500 Bks.

225815

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46555

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

11 E 46555

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 5-8 WARD)

2-FULL NAME Ida Budnick

(a) RESIDENCE NO. 421 Mott ST., WARD City

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fe.

4 COLOR OR RACE: Wht

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Max Budnick

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE: 50 Years — Months — Days — If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER Untown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER Untown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Records

(Address)

15 Filed JUN 5 - 1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1929

17 I HEREBY CERTIFY, That I attended deceased from June 3, 1929, to June 4, 1929, that I last saw her alive on June 4, 1929, and that death occurred, on the date stated above, at 7:40 P.m.

The CAUSE OF DEATH* was as follows:

Generalized Peritonitis

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of June 3-1929

Was there an autopsy? No

What test confirmed diagnosis? Operation & autopsy

(Signed) G. B. Hunt M. D.

June 4 1929 (Address) Johns Hopkins Hospital Baltimore Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Mt Carmel

DATE OF BURIAL: 6/6 1929

20 UNDERTAKER: Jack Lewis

ADDRESS: 1409 E Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 46556

E 46556 REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 2211 Mondawin ave ST. 13-59 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Sopher

(a) RESIDENCE No. 2211 Mondawin ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Fannie Sopher

6 DATE OF BIRTH (month, day, and year): May 16 1877

7 AGE: Years 52 Months Days 14. 20 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Merchant

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Isaac Sopher

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Antan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Jack Lewis (Address) 1439 E. Balto St

15 Filed ... 19 ... Registrar

JUN 5 - 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 4 1929.

17 I HEREBY CERTIFY, That I attended deceased from May 25, 1929, to June 4, 1929. that I last saw h[illegible] alive on June 4, 1929 and that death occurred, on the date stated above, at 7[illegible] m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Vaso-motor Ataxia

(duration) ? yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Donnell Wolman M. D.

VI-5, 1929 (Address) 2444 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Southern Cem DATE OF BURIAL 6/6 1929

20 UNDERTAKER: Jack Lewis ADDRESS 1439 E Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

225758 E 46557

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 46557

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. ..... WARD)

2-FULL NAME Florence Bolling

(a) RESIDENCE NO. Sparrows Pt. ST., Md WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Nov 25/28

7 AGE: Years ..... Months 6 Days 4 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md -

PARENTS

10 NAME OF FATHER: Pats Bolling

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va -

12 MAIDEN NAME OF MOTHER: Ella Herring

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. Car -

14 Informant: Friends -

(Address) .....

15 Filed ..... C. HAMILTON JONES, M. D. Registrar

JUN 5 - 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): May 29 1929

17 I HEREBY CERTIFY, That I attended deceased from May 28, 1929, to May 29, 1929,

that I last saw her alive on May 29, 1929

and that death occurred, on the date stated above, at 5-45 a m.

The CAUSE OF DEATH* was as follows:

Broncho pneumonia

(duration) ..... yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Gut Tox

(Signed) J. C. Logan Jr. M. D.

May 30, 1929 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL: JUN 1929

20 UNDERTAKER .....

ADDRESS .....

Commissioner of Health,

WM. R. WOODALL

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

11-12-66 Dr Mayer 512 Cathedral

HEALTH DEPARTMENT—CITY OF BALTIMORE

33

CERTIFICATE OF DEATH

E 46558

REGISTERED NO. **E 46558**

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1427 N. Luzerne St. WARD) 16

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William H. Metzler

(a) RESIDENCE NO. 1427 N. Luzerne ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 5. 1910

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	18	11	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Swimson + Dalzer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John H Metzler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington D.C

12 MAIDEN NAME OF MOTHER Henrietta Feinstein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Wm H. Metzler

(Address) 1427 N. Luzerne St

15 Filed JUN 5 1929 S. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 2. 1929

17 I HEREBY CERTIFY, That I attended deceased from April 25. 1929. to June 2. 1929

that I last saw him alive on June 1. 1929

and that death occurred, on the date stated above, at 1302 m.

The CAUSE OF DEATH* was as follows:

Intestinal Tuberculosis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage of Intestine

(duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) G. G. Mayer, M. D.

6-4-29 (Address) 516 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL 6/5 1929

20 UNDERTAKER William Coats — ADDRESS 1217 N. Paul

IMPORTANT—In answering questions, supply full information. Write plainly in ink. Be sure that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46559

CERTIFICATE OF DEATH

E 46559

REGISTERED NO.

1-PLACE OF DEATH Jenkins Memorial Hospital

City of BALTIMORE: (No. 1000 Caton Ave St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George Harrison Bailey

(a) RESIDENCE NO. 712 Stenton Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~ Elizabeth D Bailey

6 DATE OF BIRTH (month, day, and year) Sept. 28 1879

7 AGE — Years: 49 Months: 8 Days: 13 If LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Insurance

(b) General nature of industry, business, or establishment in which employed (or employer): Agt. Of

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Co. Md

(State or country)

PARENTS

10 NAME OF FATHER George Bailey

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Eva Harrison

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore Co. Md

14 Informant Jenkins Memorial Hospital

(Address) 1000 Caton Ave

15 Filed ..... 19 ..... HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 1929

17 I HEREBY CERTIFY, That I attended deceased from 1-25 1929, to 6/5 1929,

that I last saw him alive on 6/5 1929,

and that death occurred, on the date stated above, at 7:35 a m.

The CAUSE OF DEATH* was as follows:

Arthritis deformans Chronic

duration 3 years.

Acute abscess left thigh from abrasion (duration) yrs. mos. 4 da.

CONTRIBUTORY (Secondary) Coronary Embolus

(duration) yrs. mos. da.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frederick Smith, M. D.

, 19 (Address) Forbes Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge

Date of Burial June 7 1929

20 UNDERTAKER Robert L Stitch

ADDRESS 425 Edmondson

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46560 — 31

E 46560

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1918 Argyle St., 9-16 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Benj. Guarles

(a) RESIDENCE NO. 1918 Argyle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: C.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Mar. 6 1909

7 AGE: Years 20 | Months 2 | Days 26 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Benj. Guarles

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Margaret Boyd

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Alabama

14 Informant: Margaret Guarles

(Address): 1918 Argyle St.

15 Filed JUN 5 - 1929 19 Registrar

HARRY S. JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 2, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 2, 1929, to June 2, 1929, that I last saw h alive on June 2, 1929 and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Acute Pneumonia

Phthisis

(duration) — yrs. ? mos. ? ds.

CONTRIBUTORY (Secondary): Phthisis

(duration) 2 yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) H. L. Hall, M. D.

, 19 (Address) 4262 Belair Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary — DATE OF BURIAL: June 5, 1929

20 UNDERTAKER: Wm. H. C. Elliott — ADDRESS: 1320 Ashland Av

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 46561

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46561
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. South Baltimore General Hospital St., 24-33 Ward)

2-FULL NAME Bertha Yenker Youngbar.

(a) RESIDENCE NO. Solley, A.A.Co.Md. St., Ward
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

S. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of John Youngbar.

6 DATE OF BIRTH (month, day, and year) September 15, 1891

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	37	8	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Joseph Yenker.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant John Youngbar. (husband)
(Address) Solley, A.A.Co.Md.

15 Filed 6-19-29 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4, 1929

17 I HEREBY CERTIFY, That, I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

2nd and 3rd. degree burns by pouring oil in coal range. Accidental Death.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Solley, A.A.Co.Md. May 8, 1929

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Chas Steinhardt M. D.

6/4 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — DATE OF BURIAL 6-7 1929

20 UNDERTAKER Ehrle Slade — ADDRESS 1124 Madison

Spec.—1-12-23—M&T—500 Blks.

Edward A Bopp.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46562
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

E 46562

CITY OF BALTIMORE: (No. 625 Edgewood Ave ST. 6-20 WARD) 31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward A Bopp

(a) RESIDENCE No. above (Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Cora M. Bopp

6 DATE OF BIRTH (month, day, and year) Oct 23 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	7	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Edward A Bopp

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Eliz Neuberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Cora M. Bopp

(Address) 625 Edgewood Ave

Filed JUN 5 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1929

17 I HEREBY CERTIFY, That I attended deceased from May 25 1929 to June 4 1929, that I last saw h[illegible] alive on June 4 1929, and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical findings

(Signed) M. A. Krell M. D.

6/5, 1929 (Address) 4207 Fredrick Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL 6-8 1929

20 UNDERTAKER Ernest Harle — ADDRESS 1156 Mt Ave

INFORMATION, WITH CAREFUL ATTENTION TO THIS BLANK, IS REQUESTED. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 46563 HEALTH DEPARTMENT—CITY OF BALTIMORE E 46563

225/163 118-002

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 23-31 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Spurrell

(a) RESIDENCE NO. 1017 Race ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE B.

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word) M.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Newton Spurrell

6 DATE OF BIRTH (month, day, and year) 1902

7 AGE Years 29 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work N. W.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Randall Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Bella Ash

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 1929 . 19 H. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3 1929

17 I HEREBY CERTIFY, That I attended deceased from May 27, 1929, to June 3, 1929, that I last saw her alive on June 3, 1929, and that death occurred, on the date stated above, at 12 P m. midnight.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction due to band of adhesions constricting lower ileum and volvulus with perforation and localized peritonitis

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) Peritoneal adhesions

(duration) 5 yrs. ? mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of June 1st 1929

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) H. D. Everett, M. D.

6/4. 1929 (Address) The Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ashland (Va) DATE OF BURIAL June 6 1929

20 UNDERTAKER Sam'l W. Chase & Son ADDRESS 1400 Mosher

NOTE—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JN5

Spec.—2-29-28—L. F. S.—500 Bks.

E 46564

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

111-001

E 46564

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Univ. Hosp. St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME

(a) RESIDENCE NO. 1945 Frederick Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept. 30, 1885

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
43	8	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Augustus Bokeman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Carrie Coffell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Frank Hemmeter

(Address) 2757 Eastern Ave.

15 Filed JUN 5 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3rd, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 20th, 19 29, to June 3rd, 19 29, that I last saw h[illegible] alive on June 3rd, 19 29, and that death occurred, on the date stated above, at 7:00 A.m.

The CAUSE OF DEATH* was as follows:

Ulcer of stomach perforated, acute general peritonitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension Endocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of June 1st, 1929

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Edwin H. Funk, M. D.

June 5, 1929 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	June 6, 1929
20 UNDERTAKER	ADDRESS
Harry A. Mitze	1531 W. Lombard St.

IMPORTANT—Answer all questions as carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46565

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31

E 46565

1—PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2255 N Carlton ST. 18-76 WARD)

2—FULL NAME William Jerome Matthews (Matthews)

(a) RESIDENCE NO. 2255 N Carlton ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 31 yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married (Matthews)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Irene (Matthews)

6 DATE OF BIRTH (month, day, and year) Dec. 30, 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	31	5	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Balto (Matthews)

PARENTS

10 NAME OF FATHER Major Matthews

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Jane Emily Bailey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Frank Matthews (Matthews)

(Address) 240 Amity St

15 Filed ....., 19 .....

C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3/29

17

I HEREBY CERTIFY, That I attended deceased from March 17, 1929, to June 3, 1929, that I last saw h.. alive on June 1, 1929 and that death occurred, on the date stated above, at 1.16 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

2 1/2 months (duration) 0 yrs. 2 mos. 16 ds.

CONTRIBUTORY (Secondary) Influenza

(duration) 0 yrs. 2 1/2 mos. ..... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Laboratory, Health Dept

(Signed) J. Edw. Foker, M. D.

June 3, 1929 (Address) 1612 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	June 6, 1929
20 UNDERTAKER	ADDRESS
Mrs Katie R Williams	522 Aisquith St

IMPORTANT—This certificate should be carefully supplied. AGE should be stated EXACTLY. FIGURES should be used in all cases. Read carefully the instructions on back of certificate. OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

JUN 5 - 1929

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46566

CERTIFICATE OF DEATH

E 46566

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2700 E. Chase ST., 8-12 WARD)

2—FULL NAME VICTORIA DEMBECK,

(a) RESIDENCE NO. 2700 E. Chase ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. 6 mos. 14 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Andrew Dembeck,

6 DATE OF BIRTH (month, day, and year) Dec. 21-1890.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, MD.

PARENTS

10 NAME OF FATHER Joseph Dembeck,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland,

12 MAIDEN NAME OF MOTHER Frances Anuszewska,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland,

14 Informant Andrew Dembeck,

(Address) 2700 E. Chase St.

15 Filed JUN 5 - 1929 By C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 4, 1928, to June 4, 1929,

that I last saw her alive on June 4, 1929

and that death occurred, on the date stated above, at 1 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) E. E. Green, M. D.

6/5/29 (Address) 4058 Patterson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
ST. STANISLAUS CEMETERY	June 7. 1929.
20 UNDERTAKER M. J. Sadowski	ADDRESS 2215 Pelham Ave

IMPORTANT—Information should be carefully supplied. Name should be written in full. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 46567 (4764)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46567

CERTIFICATE OF DEATH.

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. 12-51 (WARD)

2-FULL NAME Merrill E. Hynson

(a) RESIDENCE NO. 2111 (Usual place of abode) Maryland ST., Ave. WARD

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) 1909

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	20	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Asst Mgr of Chain Store

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Geo T Hynson

11 BIRTHPLACE OF FATHER (city or town) (State or country) —

12 MAIDEN NAME OF MOTHER Sadie Olsin

13 BIRTHPLACE OF MOTHER (city or town) Va (State or country)

14 Informant Friends

(Address) JOHNS HOPKINS HOSPITAL

15 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1929

17 I HEREBY CERTIFY, That I attended deceased from Apr. 28, 1929, to June 4, 1929, that I last saw living alive on June 4, 1929, and that death occurred, on the date stated above, at 12 35 P. m.

The CAUSE OF DEATH* was as follows:

Subacute bacterial endocarditis

Aortic insufficiency

Mitral stenosis & insufficiency

more than

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Blood Culture

(Signed) C. H. Briggs M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Montecello Mf Va

DATE OF BURIAL 5/5 1929

20 UNDERTAKER Wilbur W Shriver

ADDRESS 907 Walnut Ave

UN5-1929

I. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 46568

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 46568

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Elgin & Restaurant 1275 St., Ward)

2-FULL NAME Isaac Gittlen

(a) RESIDENCE NO. 2522 Second St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Don't know

7 AGE	Years	Months	Days	IF LESS than 1 day....hrs. or....min.
40				

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Produce Merchant
(b) General nature of industry, business, or establishment in which employed (or employer) Farm products
(c) Name of employer self

9 BIRTHPLACE (city or town)
(State or country) Russia

PARENTS

10 NAME OF FATHER Samuel Gittlen

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Esther Kramer

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Morris Gittlen
(Address) 223 Green St - Harrisburg Pa

Filed JUN 5 1929 C. HAMPSON JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June - 5 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows: Fracture of Skull

(Duration) yrs. mos. ds.

CONTRIBUTORY (secondary) Accident - asleep when auto he was driving struck safety zone

(Duration) yrs. mos. ds.

(Signed) M. D.

6/5, 1929 (Address) 2939 W. Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Harrisburg Pa Date of Burial 6/5 1929

20 UNDERTAKER Ant Herrison & Bro ADDRESS 1127 E Balto St

IMPORTANT: WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46569

HEALTH DEPARTMENT—CITY OF BALTIMORE

V 122-902 E 46569

CERTIFICATE OF DEATH

1—PLACE OF DEATH U. M. H.

REGISTERED NO.

CITY OF BALTIMORE: (No. Union Memorial Hospital ST., 12-44 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mr. John W. Bear

(a) RESIDENCE NO. 1213 Franklin Rd., Roanoke, Va. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~

6 DATE OF BIRTH (month, day, and year) June 28, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	11	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Automobile Industry

(b) General nature of industry, business, or establishment in which employed (or employer) C

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Eckton Va

PARENTS

10 NAME OF FATHER Adam C Bear

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Susan Long

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Hospital Records

(Address)

15 Filed JUN 5 1929, 19 C. HAMPSON JONES, By Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 4, 1929, to June 5, 1929, that I last saw h... alive on June 5, 1929 and that death occurred, on the date stated above, at 1.45 P. m.

The CAUSE OF DEATH* was as follows:

Oesophageal tumor with atypical cancer of the lung.

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Oesophageal tumor

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Palmer F. C. Williams M. D.

6/5. 1929 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Roanoke, Virginia

DATE OF BURIAL 6/5 1929

20 UNDERTAKER Henry J. W. Jenkins' Son

ADDRESS Orchard & McCulloh.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46570

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

29

E 46570

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1430 Riverside ave ST. 24-33 WARD

2—FULL NAME Patrick William Norris.

(a) RESIDENCE NO. 1430 Riverside ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	married

a If married, widowed or divorced
HUSBAND of
(or) WIFE of Catharine M. Norris

6 DATE OF BIRTH (month, day, and year) February 26, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Locomotive Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) Railroad 030

(c) Name of employer Pensioner, B. & O. R.R. Co.

9 BIRTHPLACE (city or town) Elkridge,
(State or country) Howard County, Md.

PARENTS

10 NAME OF FATHER Edward Norris

11 BIRTHPLACE OF FATHER (city or town) County
(State or country) waterford, Ireland

12 MAIDEN NAME OF MOTHER Mary Elizabeth Nours

13 BIRTHPLACE OF MOTHER (city or town) City of Cork
(State or country) County Cork Ireland

14

Informant Mary N Norris Feast

(Address) 2033 F St. N.W. Washington DC

15

Filed N5-1929 19 C. HAMPSON JONES, M. D.
Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3, 1929.

17

I HEREBY CERTIFY, That I attended deceased from Oct. 1, 1928, to June 3, 1929.

that I last saw h alive on May 31, 1929

and that death occurred, on the date stated above, at 10.53 P m.

The CAUSE OF DEATH* was as follows:

Nephritis + Myocarditis

CONTRIBUTORY (Secondary) (duration) yrs. 8 mos. ds. Dilatation of heart.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) E. L. Pearson M.D.

6-4-1929 (Address) 514 Drury Lane

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem

DATE OF BURIAL 6/6 1929

20 UNDERTAKER J. H. Sidney Sons

ADDRESS 1318 Eight St.

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 46571

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 46571

1-PLACE OF DEATH

City of BALTIMORE: (No. 3304 Hawkins Point Road St., Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thomas G. Cook

(a) Residence No. 3304 Hawkins Point Road St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: Colored

5-Single, Married, Widowed, or Divorced, (Write the word): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: Emma J. Cook

6-DATE OF BIRTH (month, day and year): June 1871

7-AGE: 58 yrs. mos. ds.

If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Farmer

(b) General nature of Industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): A A Co. Md

PARENTS.

10-NAME OF FATHER: Henry P. Cook

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Md

12-MAIDEN NAME OF MOTHER: Sarah Sikael

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Md

14-

(Informant): Emma J. Cook (Wife)

(Address): 3304 Hawkins Point Road

15-

Filed 1929 C. HAMPSON JONES, M. Registrar.

JUN 5 - 1929

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): 6-3-29

I HEREBY CERTIFY, That I attended deceased from May 31, 1929 to June 3, 1929

that I last saw him alive on June 3, 1929

and that death occurred, on the date stated above, at 3.40 p. m.

The CAUSE OF DEATH* was as follows:

Septic infection from ischio rectal abscess

(Duration) 7 ds.

CONTRIBUTORY (Secondary): 0

(Duration) 0 yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 0

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John C Stewart, M. D.

, 19 (Address) 1704 W Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary

DATE OF BURIAL, June 6, 1929

20-UNDERTAKER: John H Toadvine

ADDRESS 1027 Hanover St

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

Reid Jr ✓ 100-01

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46572

CERTIFICATE OF DEATH.

E 46572

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. West Balto. Hospital St. 24-234 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William F. Reid Jr.

(a) RESIDENCE NO. 1703 William St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: ale.

4 Color or Race: White.

5 Single, Married, Widowed, or Divorced, (write the word): Child.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May, 23, 1924.

7 AGE: Years | Months | Days: 5, | 10. | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER William F. Reid.

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Margaret H. Allen

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Balto. Md.

14 Informant William F. Reid. (Father).

(Address) 1703 William St.

15 Filed C. HAMPSON JONES, M. D.

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) June 3rd 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Autopsy & Inquiry find that said deceased came to h__ death (Inquest, autopsy or inquiry) on the day stated above.

The CAUSE OF DEATH* was as follows:

Meningitis (Non Tubercular)

(Duration) yrs. 2 mos. 4 ds.

CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 2 ds.

June 5 1929 (Signed) F. D. Lush M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Wether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Hill Cem. Date of Burial June 6 1929

20 UNDERTAKER: C. Howard Evans ADDRESS 308 Fort Ave

N5-1929

S. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46573

CERTIFICATE OF DEATH

129

E 46573

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Md Gen Hosp. St., 1-1 Ward)

2-FULL NAME Robt. Kirsch

(a) RESIDENCE NO. 3015 O'Donnell St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Kirsch

6 DATE OF BIRTH (month, day, and year) Aug 1 - 1865

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	63	10	4 3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer,
(b) General nature of industry, business, or establishment in which employed (or employer) Balto Drydock Co.
(c) Name of employer

9 BIRTHPLACE (city or town) Denmark,
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Mary Kirsch
(Address) 3015 O'Donnell St

15 Filed ..... 19.. C. HAMPSON JONES, M. D.
Registrar

JUNE 6 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest,
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Interstetial Nephritis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? 3015 O'Donnell

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) Reblitz, M. D.

June 4, 1929 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oaklawn Cemetery — DATE OF BURIAL June 7 1929

20 UNDERTAKER George W. Zinkler — ADDRESS 1737 E. Eager St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

Sumner Pye.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46574

CERTIFICATE OF DEATH.

71-001

E 46574

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital W-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sumner Pye

(a) RESIDENCE No. 2028 McCulloh St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Colored	infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of infant

6 DATE OF BIRTH (month, day, and year) June 1926

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt. Md.

PARENTS

10 NAME OF FATHER Chas Sumner Pye

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Anita Depaw

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Chas Sumner Pye

(Address) 2028 McCulloh St

15 Filed JUN 6 1929, 19

HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 1929

17 I HEREBY CERTIFY, That I attended deceased from May 21, 1929, to June 5, 1929, that I last saw h[illegible] alive on June 5, 1929 and that death occurred, on the date stated above, at 1-15 P.M.

The CAUSE OF DEATH* was as follows:

Meningitis (Pneumococcic) Primary

(duration) yrs. mos. 22 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis? Spinal fluid.

(Signed) H. Bradley, M. D.

19 [illegible] Address [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery Catonsville DATE OF BURIAL 6/6/29

20 UNDERTAKER Edward J. Kennedy ADDRESS 1 Bank

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46575

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46575

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO. 1-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

2—FULL NAME Charles Kohlbus

(a) RESIDENCE NO. 511 S. Chapel ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary J. Kohlbus

6 DATE OF BIRTH (month, day, and year) May 7, 1878 Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	51		29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Maryland

PARENTS

10 NAME OF FATHER Elias Kohlbus Unknown

11 BIRTHPLACE OF FATHER (city or town) Balto. Md. (State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary E. Reymacle Unknown

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md. (State or country) Unknown

14 Informant Records of

(Address) Balto. City Hospitals

15 Filed JUN 6 - 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 31, 1929, to June 5, 1929, that I last saw him alive on June 5, 1929 and that death occurred, on the date stated above, at 4:15 A.M.

THE CAUSE OF DEATH* was as follows: Probable Typhoid fever

..... (duration) ..... yrs. ..... mos. 17 ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? yes Date of 6-5-29

Was there an autopsy? yes

What test confirmed diagnosis? not confirmed yet

(Signed) [illegible], M. D.

, 19 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Cemetery	June 7th 1929
20 UNDERTAKER	ADDRESS
Lilly & Gentle Sons	403 S. Wolfe St.

IMPORTANT—In answering questions, please remember that this certificate is a permanent record. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46576

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 ✓ E 46576

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 922 Hollins ST. 18-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary L. Bruff

(a) RESIDENCE NO. 922 Hollins ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~~yrs.~~ ~~mos.~~ ~~ds.~~ How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Bruff

6 DATE OF BIRTH (month, day, and year) April 11, 1850

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	79	-	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) (State or country) Baltimore County Maryland

PARENTS

10 NAME OF FATHER John Lauer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Louisa Marshall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Mrs. Stella Litz
(Address) 922 Hollins St.

15 Filed JUNE - 1929 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1929, to June 3, 1929, that I last saw her alive on June 3, 1929 and that death occurred, on the date stated above, at 6.30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Int. Nephritis

(duration) — yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) — yrs. 6 mos. — ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No. —

What test confirmed diagnosis? Clinical Symptoms

(Signed) [illegible], M. D.

6/4, 1929 (Address) 888 W. Lombard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL June 6 1929

20 UNDERTAKER [illegible]

ADDRESS 1003 West Baltimore St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46577

CERTIFICATE OF DEATH

E 46577

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Md. Gen. Hosp. St. 26-37 Ward)

2-FULL NAME Mike Babyak.

(a) RESIDENCE NO. 4312 Eastern Ave St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Babyak

6 DATE OF BIRTH (month, day, and year) 1892

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	37			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Tin Mill
(c) Name of employer Bethlehem Steel

9 BIRTHPLACE (city or town) Austria
(State or country)

PARENTS

10 NAME OF FATHER John Babyak

11 BIRTHPLACE OF FATHER (city or town) Austria
(State or country)

12 MAIDEN NAME OF MOTHER Mary Kuss

13 BIRTHPLACE OF MOTHER (city or town) England
(State or country)

14 Informant Henry Babyak
(Address) 4312 Eastern Ave

15 Filed JUNE - 1929 19 HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:
Accident
Fractured Skull.
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Struck by Empty Wheel
Right side Head
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Tin mill Sparrows Point
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Regular
(Signed) A. E. Link M. D.
June 4 19 29 (Address) Coroner.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	June 7 1929

20 UNDERTAKER Grant & Grach Sep 1906 6-L Board
ADDRESS

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

71-001

E 46578

CERTIFICATE OF DEATH

E 46578

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1027 S Hanover ST. 73-31 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alice Dezer

(a) RESIDENCE NO. 1027 S Hanover ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Feb 25 1928

7 AGE: Years 1 | Months 4 | Days 10 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Alex Dezer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greece

12 MAIDEN NAME OF MOTHER Helen Pavlesca

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Greece

11 Informant Alex Dezel

(Address) 192 S Hanover st

15 Filed JUN 6 1929 19 H. POOL JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5, 1929.

17 I HEREBY CERTIFY, That I attended deceased from May 29/29, 19 June 5/29, 19

that I last saw her alive on June 5/29 19

and that death occurred, on the date stated above, at 1 30 P m.

The CAUSE OF DEATH* was as follows:

Meningitis

Probably due to Pneumococcus

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) John B Holt M. D.

(Address) 1132 Hyde

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemtry. DATE OF BURIAL: June 6. 1929

20 UNDERTAKER: George L Ruth ADDRESS: 1735 Hedford ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46579

CERTIFICATE OF DEATH

46 ✓ E 46579

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3316 Ruckert ST. 12-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ella Grace Reininger

(a) RESIDENCE NO. 313 E North ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	M

a If married, widowed, or divorced HUSBAND of (or) WIFE of Roy N Reininger

6 DATE OF BIRTH (month, day, and year) Oct 6 86

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	8	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wife

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Jacob Thomsen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Roy N Reininger

(Address) 313 E North Ave

15 Filed JUN 8 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 29

17 I HEREBY CERTIFY That I attended deceased from Mch 13, 1928, to June 6, 1929, that I last saw h[illegible] alive on June 5, 1929 and that death occurred, on the date stated above, at 12.40 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Yes Date of Oct 10-28

Was there an autopsy? No

What test confirmed diagnosis? Histologic Study

(Signed) E. Dossler, M. D.

6/6, 1929 (Address) 10 Medical Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Westminster Md	June 8 1929
20 UNDERTAKER	ADDRESS
H M Routson	2238 N Mott

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 46580

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001

E 46580

1-PLACE OF DEATH West Balto Gen Hospt

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST. 16-10 (WARD)

2-FULL NAME Baby Boy Price

(a) RESIDENCE NO. 643 Rosedale St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 4-1929

7 AGE	Years	Months	Days	If LESS than 1 day, 8 hrs. or 30 min.
	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. City

PARENTS

10 NAME OF FATHER Robert Price

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Dora Eanes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Millville New Jersey

14 Informant Hospital record

(Address)

15 JUN 6 - 1929 HARRISON JONES, M.D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-5-1929

17 I HEREBY CERTIFY, That I attended deceased from 6/4/29, 19..., to 6/5/29, 19..., that I last saw him alive on 6/5/29, 19..., and that death occurred, on the date stated above, at 7:15 a.m.

The CAUSE OF DEATH* was as follows:

Prematurity & Cardiac failure

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? — Date of —

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) Jacob Singer, M. D.

, 19 (Address) W. Balto Genl Hoo

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park | DATE OF BURIAL June 6, 29

UNDERTAKER Wm Tuckerton Sons | ADDRESS N. Ave & Pa

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E. 46581

HEALTH DEPARTMENT—CITY OF BALTIMORE

129 E 46581

CERTIFICATE OF DEATH

1—PLACE OF DEATH St. Joseph's Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. Caroline & Chase Sts. ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME E. Virginia Rennel Rennel

(a) RESIDENCE NO. 924 E. Chase St ST., WARD

(Usual place of abode) (If non-resident give City or Town and State)

Length of residence in city or town where death occurred 17 yrs. 6 mos. 14 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Nov. 11 1904

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	24	6	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Title Guarantee & Trust Co.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER John A. Rennel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Anna L. Preller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md

14 Informant Mrs. Anna L. Rennel

(Address) 924 E Chase St

15 Filed JUN 6 - 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/5/29

17 I HEREBY CERTIFY, That I attended deceased from May 30, 1929, to June 5, 1929, that I last saw h[illegible] alive on June 5, 1929 and that death occurred, on the date stated above, at 1.55 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis and Hypertension

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) V. Wesina, M. D.

June 5, 1929 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	June 8 1929
20 UNDERTAKER	ADDRESS
Henry Troeh Sons Inc.	130 E Eager St

IMPORTANT—Physician, please fill out all items applicable to the case. Be sure that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 46582 HEALTH DEPARTMENT—CITY OF BALTIMORE E 46582

CERTIFICATE OF DEATH.

100

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1015 W. Lafayette St. 16-23 WARD REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ocrum K. Armistead

(a) RESIDENCE NO. 1015 W. Lanvale ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE~~ Tacey L. Armistead

6 DATE OF BIRTH (month, day, and year) 6-14-1871

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
57	11	21	20

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Waiter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Chesapeake S.S. Co.

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Oliver Armistead

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Susan Dawsm

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Tacey L. Armistead (Address) 1015 W. Lanvale St

15 Filed JUN 6-1929 C. HAMPSON JONES, Registrar By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-4- 1929

17 I HEREBY CERTIFY, That I attended deceased from May 29, 1929, to June 4, 1929, that I last saw him alive on June 4, 1929, and that death occurred, on the date stated above, at 5.10 P. m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos 7 ds.

(ACUTE) CONTRIBUTORY (Secondary) Nephritis and embolism

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. White, M. D.

, 19 (Address) 1029 Madison Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery — DATE OF BURIAL: 6-7- 1929

20 UNDERTAKER: John M. Johnson — ADDRESS 1234 Etting St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 46583

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

E 46583

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph Hospital St. 10-14 Ward)

2-FULL NAME Robert E. Lenhardt

(a) RESIDENCE NO. 1023 Wilcox St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ''

6 DATE OF BIRTH (month, day, and year) Sept. 17, 1928

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
		8	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.

(State or country)

PARENTS

10 NAME OF FATHER Samuel Lenhardt

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Anna Fisher

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore Md.

14 Informant Mrs. Anna M. Lenhardt

(Address) 1023 Wilcox St.

Filed JUN 5 - 1929 W. STEPHEN SMITH Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5. 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Bronchopneumonia

(Primary)

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY

(Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) J. H. Cales M. D.

(Coroner)

6*5/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death....yrs....mos....ds. In the State....yrs....mos....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Most Holy Redeemer Cem. Date of Burial June 7, 1929

20 UNDERTAKER Edwin H. Conklin ADDRESS 924 E Eager St.

N. B.—WRITE PLAINLY WITH PEN AND INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

46584

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 46584

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 705 Josephine ST. 4-16 (WARD)

2-FULL NAME Sadie Hicks

(a) RESIDENCE NO. 705 Josephine ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. 4 mos. 18 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Samuel Hicks

6 DATE OF BIRTH (month, day, and year): Jan-17-1891

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
38	4	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Bag Sorter

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer: S. Shagon

9 BIRTHPLACE (City or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER William Holmes

11 BIRTHPLACE OF FATHER (City or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Lucy

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Maryland

14 Informant (Address) Harrison Black 522 Calvert St

15 Filed JUN 6 1929 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/4 1929

17

I HEREBY CERTIFY, That I attended deceased from 5/25 1929 to 6/4 1929, that I last saw her alive on 6/3 1929, and that death occurred, on the date stated above, at 5 0 m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) — yrs. 5 mos. + ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) — yrs. — mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Dan Crumbine M. D.

, 19 (Address) 122 N Eden St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn | DATE OF BURIAL June 7 1929

20 UNDERTAKER O. A. Brown & Son | ADDRESS 1010 W. Mulberry

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46585

CERTIFICATE OF DEATH.

E 46585

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2-S. Broadway St. 3-4 90 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Charles Brenton

(a) Residence No. 2-S. Broadway St., Ward.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: Male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced, (Write the word.): Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year): Oct 2 1888

7-AGE: 40 yrs. 8 mos. 3 ds.

If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Salesman

(b) General nature of Industry, business, or establishment in which employed (or employer): Bakery

(c) Name of employer: Koerber

9-BIRTHPLACE (city or town) (State or Country): Baltimore

PARENTS

10-NAME OF FATHER: John S Brenton

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Baltimore

12-MAIDEN NAME OF MOTHER: Ella E McComas

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Baltimore

14- (Informant) Garlett Brenton

(Address) 2-S Broadway

15- Filed JUN 6 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): June 5, 1929

17- I HEREBY CERTIFY, That I attended deceased from June 15 1929 to June 5 1929.

That I last saw h.. alive on June 5 1929.

and that death occurred, on the date stated above, at 8 30 P m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

following Influenza

(Duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Cerebral Embolism

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Herman J Gerring M. D.

June 6, 1929 (Address) 1900 Eastern Av

*State the **Disease Causing Death**, or in deaths from **Violent Causes**, state (1) **Means and Nature of Injury**, and (2) whether **Accidental, Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: June 7 1929

20-UNDERTAKER: George Smith Holmes

ADDRESS 1532

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46586

CERTIFICATE OF DEATH

90 E 46586

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Pronounced dead at Balt. City Hospitals 6-29

City of Baltimore: (No. ..... St. ..... Ward)

2-FULL NAME John A Kiser

(a) RESIDENCE NO. 3505 Esther Rd St., ... Ward

(Usual place of abode)

Length of residence in city or town where death occurred 34 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Mal

4 Color or Race: Wht

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 6/1890

7 AGE — Years: 39 | Months: 5 | Days: 29 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Time Keeper
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: Paper Bag Co

9 BIRTHPLACE (city or town)
(State or country): W Virginia

PARENTS

10 NAME OF FATHER: John A Kiser

11 BIRTHPLACE OF FATHER (city or town)
(State or country): W. Virginia

12 MAIDEN NAME OF MOTHER: Sarah Shuler

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): W Virginia

14 Informant: Dorothy Kiser
(Address): 3505 Esther

15 Filed ..... 192 ..... C. HAMPSON JONES, M. D. Registrar

JUN 6 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis (Probably Syphilitic)

(duration) Sudden yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? 3505 Esther Rd

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M. Hutton M. D.

June 5, 1929 (Address) 700 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: June 8 1929

20 UNDERTAKER: Charles H Eichner — ADDRESS: 1552 Hollins

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46587

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46587
REGISTERED NO.

1—PLACE OF DEATH University Hospital
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Greene & Lombard ST. 26-41 WARD)

2—FULL NAME Mary Carback.

(a) RESIDENCE NO. 520 Bloomfield ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: E Wm Carback

6 DATE OF BIRTH (month, day, and year): Dec 19, 1869

7 AGE: Years 59 | Months 5 | Days 16 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS
10 NAME OF FATHER: John T Washburn
11 BIRTHPLACE OF FATHER (city or town) (State or country): Md
12 MAIDEN NAME OF MOTHER: Sarah E Green
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: E William Carback
(Address) 520 Bloomfield Ave

15 Filed JUN 6 1929, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 5, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 28, 1929, to June 5, 1929, that I last saw h[illegible] alive on June 4, 1929, and that death occurred, on the date stated above, at 7:20 A m.

The CAUSE OF DEATH* was as follows:
Carcinoma of stomach
(duration) — yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary): Broncho pneumonia
(duration) 7 yrs — mos. 5 ds.

18 Where was disease contracted if not at place of death? Unknown.
Did an operation precede death? Yes Date of May 30, 1929
Was there an autopsy? Yes
What test confirmed diagnosis? Physical Examination
(Signed) [illegible] M. D.
, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cem	June 8 1929
20 UNDERTAKER: Charles H Hechner	ADDRESS 453 Fallis

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46588

CERTIFICATE OF DEATH.

88-103

E 46588

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. City Hosp. St. 26-2 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jos. W. McClelland

(a) RESIDENCE NO. 3210 E. Lombard St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wilhelmina C.

6 DATE OF BIRTH (month, day, and year) May 3/79

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	50	1	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Night Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) Copper works

(c) Name of employer

9 BIRTHPLACE (city or town) City

(State or country)

PARENTS

10 NAME OF FATHER Wm McClelland

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Eliza —

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Wilhelmina C. McClelland

(Address) 3210 E. Lombard St

15 Filed JUN 6-1929 G. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1929

17 I HEREBY CERTIFY, that I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Dilatation of Heart

Multiple Fractures

(Duration) yrs. mos. 20 ds.

CONTRIBUTORY (Secondary) Exhaustion

(Duration) yrs. mos. 1 ds.

Signed G. C. Bladel M. D.

(Coroner)

19 (Address) 1423 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? East on Elliott St

Former or usual residence

PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Cem. Date of Burial June 7 1929

20 UNDERTAKER Philip Herwig ADDRESS 2016 Orleans St

If death occurred in a hospital or institution, give its NAME instead of street and number. Fill in all items, and make them complete and accurate. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46589

CERTIFICATE OF DEATH

E 46589

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital WARD 10-57

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Susbie M. Rigney

(a) RESIDENCE NO. 1304 Dellwood Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. 5 mos. 20 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph B. Rigney

6 DATE OF BIRTH (month, day, and year) Jan 17 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	5	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Inhoff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Fredricksburg Va

12 MAIDEN NAME OF MOTHER Mary Edrington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

11 Informant Joseph B. Rigney

(Address) 1304 Dellwood Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 5 1929 to June 6 1929.

that I last saw h er alive on June 6 1929

and that death occurred, on the date stated above, at 1.10 a m.

The CAUSE OF DEATH* was as follows:

Scarlet Fever

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Acute Hemorrhagic Nephritis (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? 1304 Dellwood Ave

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) Addison Craft Irby, M. D.

6-6 1929 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem

DATE OF BURIAL June 7 1929

20 UNDERTAKER Chenoweth Son

ADDRESS

JUN 6-1929 HAMILTON JONES, M. D. Registrar

OF DEATH in plain terms, so that it may be properly classified. Last statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

Patricia Drake.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46590

CERTIFICATE OF DEATH.

31

REGISTERED NO. E 46590

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (NO. 722 Ensor St., 10-4 WARD)

2-FULL NAME Patricia Drake

(a) RESIDENCE NO. 722 Ensor St., WARD
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: C.

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 5, 1928

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or..... min.
	1	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER John Drake

11 BIRTHPLACE OF FATHER (city or town) (State or country) S.C.

12 MAIDEN NAME OF MOTHER Annie Blackwell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S.C.

14 Informant John Drake
(Address) 722 Ensor St.

Filed JUN 6 1929 H. HAMBURG JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 1929

17 I HEREBY CERTIFY, That I attended deceased from June 4, 1929, to June 5, 1929, that I last saw h/ alive on June, 1929, and that death occurred, on the date stated above, at 1230 m.

The CAUSE OF DEATH* was as follows:

Pleurisy

Broncho Pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Pleurisy (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of no

Was there an autopsy? no

What test confirmed diagnosis? Positive

(Signed) J. H. Brown, M. D.

June 6, 1929 (Address) 118 W Hamburg St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary — DATE OF BURIAL: June 6, 29

20 UNDERTAKER: Mrs. P. J. Elliott — ADDRESS: 1725 Ashland Ave

Before signing be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 46591

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 46591

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. 3-5 WARD)

2-FULL NAME George Languish

(a) RESIDENCE NO. 911 N. Lombard ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., If of foreign birth? 29 yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work... Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER Yousarp Languish

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Anna Kamsinor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUN 6-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 1929

17 I HEREBY CERTIFY, That I attended deceased from March 20, 1929, to June 5, 1929,

that I last saw him alive on June 5, 1929,

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Streptococcus Endocarditis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Blood Culture.

(Signed) C D Briggs M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Holy Redeemer — DATE OF BURIAL June 8 1929

20 UNDERTAKER John Grebbiancus — ADDRESS 4238 Penn

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—I. F. S.—500 Bks.

Burial Order

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46592 — 161-001 — E 46592

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 2302 Belair Rd ST., 45 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thomas W Coleman

(a) RESIDENCE NO. 2302 Belair Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 5- 1929

7 AGE — Years: — Months: — Days: — If LESS than 1 day, hrs. or min.: 7

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Thomas W Coleman

11 BIRTHPLACE OF FATHER (city or town) (State or country): North Carolina

12 MAIDEN NAME OF MOTHER: Thelma Starth

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Catherine Starth

(Address) 2302 Belair Road

15 Filed 6-1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 6-1929

17 I HEREBY CERTIFY, That I attended deceased from 6/5, 1929, to 6/6, 1929

that I last saw h alive on , 19

and that death occurred, on the date stated above, at 1:04 a.m.

The CAUSE OF DEATH* was as follows:

Premature Birth (7½ mos)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Gustave A Ritt, M. D.

6/6, 1929 (Address) Arden.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery — DATE OF BURIAL: 6/6 1929

20 UNDERTAKER: Wm Cook — ADDRESS: 121 Saratoga

N 6-1929

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46593 90 E 46593

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO. 28-64

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Susie Cunningham

(a) RESIDENCE NO. 5102 Norwood Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 86 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	86			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Cunningham

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Records of

(Address) Baltimore City Hospitals

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

Per .....

N 6-1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 25, 1929 to June 5, 1929

that I last saw her alive on June 5, 1929

and that death occurred, on the date stated above, at 11:30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

myocardial insufficiency

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) senility - decubitus ulcer

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no What test confirmed diagnosis? Physical Exam.

(Signed) Morris [illegible], M. D.

, 19 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Cathedral — DATE OF BURIAL 6/7 1929

20 UNDERTAKER W. W. Cook — ADDRESS 1117 St. Paul

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46594

CERTIFICATE OF DEATH

161-002

E 46594

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 313 S. Wolfe St., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Infant Mielcharek

(a) RESIDENCE NO. 313 S. Wolfe ST., WARD 2
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 6-6-29

7 AGE: Years: 1 day | Months: | Days: | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: infant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto, Md

PARENTS

10 NAME OF FATHER: Vincent Mielcharek

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Mary Pietrzak

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Mr Vincent Mielcharek

(Address): 313 S. Wolfe St

15 Filed ..., 19 ... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6-6 29

17 I HEREBY CERTIFY, That I attended deceased from 6-6 29, to 6-6 29, that I last saw h alive on 6-6 29, and that death occurred, on the date stated above, at 4 P. M.

The CAUSE OF DEATH* was as follows:

Prec[illegible]-Transverse Presentation

(duration) hr. mos. ds.

CONTRIBUTORY (Secondary) Congenital Atelectasis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? [illegible]

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Gross Pathology

(Signed) [illegible] M. D.

6-7 29 (Address) 800 Orleans St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — DATE OF BURIAL: June 7 1929

20 UNDERTAKER: John M Weber — ADDRESS: 401 E Chester St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Blks.

Gisa

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46595

CERTIFICATE OF DEATH

90 E 46595

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2526 E. Fayette St. 70-69 Ward)

2-FULL NAME Antonia Gisa

(a) RESIDENCE NO. 2526 E. Fayette St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Martin Gisa

6 DATE OF BIRTH (month, day, and year) Jan 10/1888

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	41	4	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) at home
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Poland

PARENTS

10 NAME OF FATHER Frank Krzyskaska

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland

14 Informant Martin Gisa
(Address) 2320 E. Fayette St

15 Filed ..., 19.. C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardiac Valv. Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Dr. Dr Rysanek

(Signed) J. H. Bacon, M. D.

6/6/29 19 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rozary	June 10 1929
20 UNDERTAKER	ADDRESS
John M Weber	401 E. Chase St

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JUN 6 1929

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46596

CERTIFICATE OF DEATH

90 E 46596

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St. 24-32 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Miss Katie Reardon

(a) RESIDENCE NO. 1274 Riverside Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) – 1869

7 AGE Years: 60 Months: – Days: 7 IF LESS than 1 day..... hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md.

PARENTS

10 NAME OF FATHER: John Reardon

11 BIRTHPLACE OF FATHER (City or town): Ireland

(State or country)

12 MAIDEN NAME OF MOTHER: Mary Boylan

13 BIRTHPLACE OF MOTHER (city or town): Maryland

(State or country)

14 Informant: Mrs. Schuster

(Address): 1712 Riverside Ave

15 Filed: 6-1929 C. HAMPSON JONES, M. D. Registrar

Per: M.R.B.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/5/29 19

17 I HEREBY CERTIFY, That I attended deceased from 6/1/29, 19..., to 6/5/29, 19..., that I last saw her alive on 6/5/29, 19..., and that death occurred, on the date stated above, at 9 P.M. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerotic Cardio Vascular Disease Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Nephritis (duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) J. S. Whitehead M. D.

19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lakewood Cem

Date of Burial: 6/8 19 29

20 UNDERTAKER: Potts & Sons

ADDRESS: 1311 Eutaw St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46597 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 38 E 46597

1—PLACE OF DEATH

REGISTERED NO. 12-26

CITY OF BALTIMORE: (No. University Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Eable

(a) RESIDENCE NO. Dorsey, Md. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred [illegible] yrs. mos. 8 ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Divorced.

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 7, 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	6	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Assistant Accountant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer B & O. Railroad.

9 BIRTHPLACE (city or town) (State or country) Pennsylvania.

PARENTS

10 NAME OF FATHER Samuel Eable

11 BIRTHPLACE OF FATHER (city or town) (State or country) McKeesport Pa

12 MAIDEN NAME OF MOTHER Jenny Scott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Nebraska

14 Informant Anne Eable (daughter)
(Address) Dorsey Md

15 Filed JUN 6 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 1929

17 I HEREBY CERTIFY, That I attended deceased from May 28, 1929, to June 5, 1929, that I last saw him alive on June 5, 1929, and that death occurred, on the date stated above, at 8:30 P. m.

The CAUSE OF DEATH* was as follows:

Ruptured Aneurysm Aortic Root. Hypotension, Cardiac Hypertrophy.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Rupture of Aneurysm

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? "

Did an operation precede death? No. Date of

Was there an autopsy? yes.

What test confirmed diagnosis? autopsy.

(Signed) C. T. Limbach, M. D.

. 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Knoxville Md	June 8 1929

20 UNDERTAKER H. Howard Evans ADDRESS 35 E. Fort Ave

IMPORTANT. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46598

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001

E 46598

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3640 Falls Road St. 13-37 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Infant of Lonnie & Margaret Howard.

(a) RESIDENCE NO. 3640 Falls Road ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 5 1929.

7 AGE: Years | Months | Days: 1 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore city Md.

PARENTS

10 NAME OF FATHER: Lonnie C. Howard.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Margaret E. Reid

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Lonnie C. Howard.

(Address) 3640 Falls Rd

15 Filed JUN 6 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 6 1929

17 I HEREBY CERTIFY, That I attended deceased from June 5, 19 29, to June 6, 19 29

that I last saw him alive on June 5, 19 29

and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Premature Gestation

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Gross appearance

(Signed) C. H. Jones M. D.

June 6, 19 29 (Address) 3707 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: St Mary's Cem. Hampden — DATE OF BURIAL: June 7, 19 29

20 UNDERTAKER: J. Walter Davis — ADDRESS: 3307 Paine St

JUN 6 1929

IMPORTANT. See instructions on back of certificates. Of DEATH in plain terms, so that it may be properly classified. Exact statement of cause is very

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46599

CERTIFICATE OF DEATH.

74 1001

E 46599

REGISTERED NO.

1-PLACE OF DEATH Franklin Square Hospital

CITY OF BALTIMORE: (No. ..... ST. 7-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Mary Shaw

(a) RESIDENCE NO. 9 South Castle ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mr Augustus Shaw

6 DATE OF BIRTH (month, day, and year) May 10. 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
54	54		26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Philadelphia (State or country) Penn.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs Sara Lafortezza (Daughter)
(Address) 9 South castle

15 Filed JUN 7-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 - 1929

17 I HEREBY CERTIFY, That I attended deceased from June 1 . 1929 . to June 5 . 1929.

that I last saw her alive on June 5 th . 1929

and that death occurred, on the date stated above, at 9:04 A m.

The CAUSE OF DEATH* was as follows:

Meningitis - pyogenic

(duration) ... yrs. ... mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Lumbar puncture

(Signed) C. W. Leake M. D.

June 5. 1929 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery

DATE OF BURIAL 5/7 1929

20 UNDERTAKER Lee & Irwin Co Inc

ADDRESS 1127 E Balto St

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46600

CERTIFICATE OF DEATH

90

E 46600

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 2824 Hemlock St. 27-43 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theresa M. Ebert

(a) RESIDENCE NO. 2824 Hemlock Rd St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frederick W. Ebert

6 DATE OF BIRTH (month, day, and year): May 27th 1847

7 AGE — Years: 82 Months: 0 Days: 9 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Work

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (City or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Julia H. Schiller

(Address) 2824 Hemlock Av.

15 Filed JUN 7-1929 19 C. HAMPSON JONES, M. D. Registrar

Per KLH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 6th 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb 1st, 1929, to June 6th, 1929, that I last saw her alive on June 5th, 1929, and that death occurred, on the date stated above, at 5:30 A m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no What test confirmed diagnosis? Clinical

(Signed) L. L. Sordy M. D.

6-6, 1929 (Address) 421 Woodland Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem. Date of Burial: June 8th 1929

20 UNDERTAKER: E. Schloman & Son ADDRESS 1029 Hanover

NOTE—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46601

CERTIFICATE OF DEATH.

E 46601

100-801

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1515 W. Balto ST. 19-28 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ethel Jessie Nagengast

(a) RESIDENCE NO. 1515 W. Balto ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 22-1928

7 AGE: Years — Months 11 — Days 14 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country)

PARENTS

10 NAME OF FATHER Marion F. Nagengast

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country)

12 MAIDEN NAME OF MOTHER Elizabeth Kinkead

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country)

14 Informant Marion F. Nagengast (Address) 1515 W. Balto St

Filed JUN 7 1929, 19 C. HAMPSON JONES, M. D. Registrar

By —

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1929

17

I HEREBY CERTIFY, That I attended deceased from May 30, 1929, to June 6, 1929, that I last saw her alive on June 5, 1929, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

I Broncho-Pneumonia

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No. Date of —

Was there an autopsy? No.

What test confirmed diagnosis? —

(Signed) Henry Nuels Lewis M. D.

June 6, 1929 (Address) 933 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: June 7, 1929

20 UNDERTAKER: Fred A. Lahmeyer & Son — ADDRESS: 703 Hanover

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46602

CERTIFICATE OF DEATH

E 46602

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Franklin Sq Hospital St., 8-29 Ward)

2-FULL NAME C. Carmelita O'Brien

(a) RESIDENCE NO. 1305 W Baltimore St., Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1925

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	4	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto City
(State or country)

PARENTS

10 NAME OF FATHER John P. O'Brian

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Balto City

12 MAIDEN NAME OF MOTHER Mary V. Wade

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Balto City

14 Informant John P. O'Brian
(Address) 1305 W. Balto St

15 Filed ..... 19 .....
CLEMENSON JONES, M. D.
Registrar

JUN 7 - 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jun 6 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Burns -
(Clothing caught fire playing with matches in the back yard)
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Chas H Moore M. D.

Jun 6. 1929 (Address) 3601 3rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Peters	June 8 1929
20 UNDERTAKER John Fields	ADDRESS 1200 N Lombard

NO. 8—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46603

CERTIFICATE OF DEATH.

E 46603

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hospital WARD 17-55

2-FULL NAME Baby Hudson

(a) RESIDENCE NO. 3307 Eaton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6-2-29

7 AGE: Years | Months | Days 4 days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Paul Hudson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER Mildred Hallen

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mildred Hudson (Address) 3307 Eaton St

15 Filed JUN 7 1929, 19 HAMPSON JONES, M. D. Registrar

For

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-5- 1929

17 I HEREBY CERTIFY, That I attended deceased from 6-2- , 1929, to 6-5- , 1929.

that I last saw h[illegible] alive on 6-5- , 1929,

and that death occurred, on the date stated above, at 4.35 a m.

The CAUSE OF DEATH was as follows:

Atelectasis

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) H. L. Jacobs M. D.

6/6 1929 (Address) 604 Washington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL June 7 1929

20 UNDERTAKER John H Toadvine — ADDRESS 1027 Hanover

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46604

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

E 46604

CERTIFICATE OF DEATH

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO. 19-27

CITY OF BALTIMORE: (No. ST., WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie Terry

(a) RESIDENCE NO. 735 Caroline St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Negro	?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Charles Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Frankie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant Recorded
(Address) BALTIMORE CITY HOSPITALS

15 Filed JUN 7 1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-6-29

17 I HEREBY CERTIFY, That I attended deceased from 1-10, 19 29, to 6-6, 19 29, that I last saw h[er] alive on 6-6, 19 29 and that death occurred, on the date stated above, at 5 30 A m.

The CAUSE OF DEATH* was as follows:

Hemorrhage into Cerebrum

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Hypertension; Arteriosclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Course

(Signed) Warren K. Wilson, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Calvary Cem.	June 8 19 29
20 UNDERTAKER Samuel H. Weinberg	ADDRESS 1132 N. Gay St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46605

CERTIFICATE OF DEATH

E 46605

REGISTERED NO.

1—PLACE OF DEATH 1642 E. Monument St. 1-13 31

CITY OF BALTIMORE (No. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sarah Senter Fellman

(a) RESIDENCE NO. 1642 E. Monument St. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 31 yrs. 1 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of: Berkley Gordon

6 DATE OF BIRTH (month, day, and year): Feb. 15th 1898

7 AGE — Years: 31 | Months: 3 | Days: 18 | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Maid

(b) General nature of industry, business, or establishment in which employed (or employer): Private

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Levi Fellman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Penna.

12 MAIDEN NAME OF MOTHER: Amanda Pitts

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Amanda Fellman

(Address) 1642 E Monument St

Filed JUN 7 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6-3-29

I HEREBY CERTIFY, That I attended deceased from 5-25-29, 19..., to 6-3, 19 29.

that I last saw her alive on 5-29-, 19 29

and that death occurred, on the date stated above, at 3:20 a. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

Pulmonary Phthisis

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. B. Butler, M. D.

, 19 (Address) 4257 N. Caroline Street

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: June 19 29

20 UNDERTAKER: Samuel H. Heusler — ADDRESS: 1 W Biddle

Of DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46606

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 46606

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Baltimore City Hosp. 4-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret Rogers

(a) RESIDENCE NO. 1822 Brunt ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem.

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Weder

6 DATE OF BIRTH (month, day, and year) 1844

7 AGE — Years: 85 | Months: | Days: | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Benj. Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Charlotte ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Hospital Records.
(Address)

15 Filed JUN 7 1929 HAMILTON JONES M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/4/29

17 I HEREBY CERTIFY, That I attended deceased from 12/1, 1928, to 6/4, 1929

that I last saw h[illegible] alive on 6/4/, 1929

and that death occurred, on the date stated above, at 5:10 P. m.

The CAUSE OF DEATH* was as follows:

Generalized tuberculosis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. U. Campbell, M. D.

6/5, 1929 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	6-8-29
20 UNDERTAKER	ADDRESS
Dan'l Easter	Balto

Or DEATH in plain terms, so that it may be properly classified. Each statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 46607 HEALTH DEPARTMENT—CITY OF BALTIMORE E 46607

CERTIFICATE OF DEATH.

24-001

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2219 Oak ST. 12-51 WARD)

2-FULL NAME Wm Mitchell

(a) RESIDENCE NO. 2219 Oak St ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Mitchell

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
S	51	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va,

PARENTS

10 NAME OF FATHER Jacob Mitchell

11 BIRTHPLACE OF FATHER (city or town) Va,
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Armstead Mitchell
(Address) 2219 Oak St

15 Filed JUN 7 1929 19 C. HARRISON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 1929

17 I HEREBY CERTIFY, That I attended deceased from April 19, 1929, to June 5, 1929, that I last saw him alive on June 5, 1929, and that death occurred, on the date stated above, at 3,40 P. m.

The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(duration) — yrs. — mos 47 ds.

CONTRIBUTORY (Secondary) None
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. C. Patterson, M. D.
, 19 (Address) 512 Hamilton Ter.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL 6-8 1929

20 UNDERTAKER Dan'l Carter — ADDRESS Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46608 HEALTH DEPARTMENT—CITY OF BALTIMORE 31 E 46608

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. .....

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST., 4-25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Stevenson

(a) RESIDENCE NO. 645 Vine st. ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER James Stevenson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Fannie Swanson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records

(Address) .....

15 Filed JUN 7 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 4, 19 29, to June 5, 19 29, that I last saw h.. in alive on June 5, 19 29 and that death occurred, on the date stated above, at 10.45 P. m.

The CAUSE OF DEATH* was as follows:

Caseous pneumonia

..... (duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) .....

..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical and lab.

(Signed) Henry C Smith, M. D.

6-6-, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Richmond Va	June 7 1929
20 UNDERTAKER	ADDRESS 1025 Hull
Jos H Trader	

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46609 182 ✓ E 46609

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Body found floating at the Foot of Andre St. St., 72-33 Ward)

2-FULL NAME Louis Scline.

(a) RESIDENCE NO. 125 E. Churchill St. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. 5 mos. 4 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White.	Widower

5a If ~~XXXXX~~ widowed, ~~XXXXXX~~ HUSBAND of ~~XXXXXXXX~~ Annie Scline.

6 DATE OF BIRTH (month, day, and year) January 1, 1859

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	70	5	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Watchman.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Lillian McKnight. (daughter)
(Address) 125 E. Churchill St-

15 Filed ..... 19 .....

C. HARRISON JONES, M. D. Registrar

JUN 7-1929 Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Body found June 5, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning.

Accidental fall from a boat.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M Leuhardt, M. D.

6/7, 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross	June 7 1929
20 UNDERTAKER John F. Denny	ADDRESS 7 Light

Spec.—1-10-21—M&T—1500 Bks.

E 46610

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 46610

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. 5-9 WARD)

2-FULL NAME Rachael Wilson

(a) RESIDENCE NO. 11 N. Eden St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced, (write the word) Wid

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H.W.

(b) General nature of industry, business, or establishment in which employed (or employer) 090

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Wm

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Laura Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Records

(Address)

15 Filed G. HAMILTON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1 1929

17 I HEREBY CERTIFY, That I attended deceased from May 27, 1929, to June 1, 1929, that I last saw her alive on June 1, 1929, and that death occurred, on the date stated above, at 9.25 P m.

The CAUSE OF DEATH* was as follows:

Extensive tuberculous salpingitis, and extensive tuberculous peritonitis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Old pulmonary tuberculosis

(duration) ? yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death? H & time

Did an operation precede death? Yes. Date of May 28, 1929

Was there an autopsy? Yes.

What test confirmed diagnosis? Microscopic examination of peritoneal tissue.

(Signed) H. L. Everett, M. D.

6/4, 1929 (Address) The Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

JOHNS HOPKINS HOSPITAL

Dept. of Municipal Health.

JUN 7 - 1929

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—5-19-13—M. & T.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46611

CERTIFICATE OF DEATH.

44 V

E 46611

REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1213 Mulberry St.) 18-26 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John. Freyer

(Residence in Baltimore: No. 1213 Mulberry St.) 80 yrs., mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M.

4-COLOR OR RACE, W.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) M.

6-DATE OF BIRTH, June (Month) 12 (Day), 1846 (Year)

7-AGE, 82 yrs. 4 mos. 24 25 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Germany

PARENTS.

10-NAME OF FATHER, Conrad Freyer

11-BIRTHPLACE OF FATHER (State or Country), Germany

12-MAIDEN NAME OF MOTHER Mary L. Freyer

13-BIRTHPLACE OF MOTHER (State or Country), Germany

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Emma Freyer

(Address) 1213 W. Mulberry st.

15- JUN 7 1929

C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 6, (Day), 1929 (Year).

17- I HEREBY CERTIFY, That I attended deceased from June 1 1929, to June 6 1929, that I saw [illegible] alive on June 6 1929, and that death occurred, on the date stated above, at 5.45 m.

The CAUSE OF DEATH* was as follows:

a Gastric Carcinoma

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Weakness

(Duration) yrs. mos. 3 ds.

(Signed) A. D. Driscoll M. D.

, 191... (Address) 1211 Mulberry St

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL. Loudon Park

DATE OF BURIAL, 6-8-, 1929

20-UNDERTAKER H. Brownings Son.

ADDRESS 1136 Poplar Grove St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Sped.—2-29-28—L. F. S.—500 Bks.

E 46612 HEALTH DEPARTMENT—CITY OF BALTIMORE 118-002 E 46612

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Balto. City Hosp. ST. 7-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Abe Williams

(a) RESIDENCE NO. 921 Wilmot ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Indiana

PARENTS

10 NAME OF FATHER Abe Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Lizzie Graves (Address) 1922 Wilmot St.

15 Filed JUN 7 1928 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/4/28

17 I HEREBY CERTIFY, That I attended deceased from 6/3, 1928, to 6/4, 1928, that I last saw him alive on 6/4, 1928, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Volvulus of the Sigmoid

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Intestinal obstruction

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? yes Date of 6/4/28

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) H. M. Crumpton, M. D.

6/6, 1928 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	June 8th 1928
UNDERTAKER Mrs. R. A. Elliott	ADDRESS 1227 Eastlandon

DO NOT WRITE IN THIS SPACE

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is necessary important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46613

CERTIFICATE OF DEATH.

1475 E 46613

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL (ST.) 5-8 (WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa Childs

(a) RESIDENCE NO. 240 N. Exeter ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	married

5a If married, widowed, or divorced
HUSBAND ~~of~~
(or) WIFE of Clarence Childs

6 DATE OF BIRTH (month, day, and year) 3/17/90

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	2	20.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Wm Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Ella Bartlett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUN 7 - 1929 HAMILTON JONES, M. D. Registrar

By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4th 1929

17

I HEREBY CERTIFY, That I attended deceased from June 1st, 1929, to June 4th, 1929, that I last saw her alive on June 4th, 1929, and that death occurred, on the date stated above, at 8 55 p. m.

The CAUSE OF DEATH* was as follows:

Unknown

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) Childbirth (macerated fullborn) (duration) — yrs. — mos. 3 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Ludwig A. Manchetti M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary — DATE OF BURIAL June 7 1929

UNDERTAKER Wm. R. A. Elliott — ADDRESS 1323 Ashland Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46614

CERTIFICATE OF DEATH.

90 v

E 46614

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 28-E-20 St 12-51 St. 12 Ward)

2-FULL NAME George Parrell

(a) RESIDENCE NO. 28 E 20 St St. 12 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 49 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: C.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Mar. 15 1880

7 AGE: Years 49 Months 2 Days 20 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Md.

(State or country)

PARENTS

10 NAME OF FATHER: John Parrell

11 BIRTHPLACE OF FATHER (city or town): Md.

(State or country)

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Unknown.

14 Informant: Mary Parrell

(Address) 28 E. 20th St.

15 Filed....., 19..... HAMPSON JONES, M.D. Registrar

JUN 7 - 1927

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-5 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tubercular Disease of Heart

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) John Mottsay M. D.

(Coroner)

6/6, 1927 (Address) 7632 Roland av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Berlin Md. Date of Burial: June 7 1927

20 UNDERTAKER: Mrs. R. A. Elliott ADDRESS: 1725 Ashland av

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46615 — 1—PLACE OF DEATH

126

E 46615 — REGISTERED NO.

CITY OF BALTIMORE: (No. Saint Joseph's Hospital ST. 7C WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Robert E. Kenny

(a) RESIDENCE NO. 119 S. Clinton ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JUN 7 - 1927

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced — HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec 27 1906

7 AGE — Years: 22 | Months: 5 | Days: 7 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Land Scape

(b) General nature of industry, business, or establishment in which employed (or employer): Gardening

(c) Name of employer: Washington D.C.

9 BIRTHPLACE (city or town) (State or country): Washington D.C.

PARENTS

10 NAME OF FATHER: John P Kenny

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Rosie Regan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Rosie Franklin (Address) 1192 Clinton St

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/4/27

17 I HEREBY CERTIFY, That I attended deceased from 6/2, 1927, to 6/4, 1927, that I last saw him alive on 6/4, 1927, and that death occurred, on the date stated above, at 7:06 P. m.

The CAUSE OF DEATH* was as follows:

Undetermined

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Pericarditis

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 6/3/27

Was there an autopsy? no Diagnosis Confirmed

What test confirmed diagnosis? Clinical

(Signed) Louis J. Littman, M. D.

, 19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Cathedral — DATE OF BURIAL: June 8 1927

20 UNDERTAKER: J. J. Doran — ADDRESS: 3700 E Balto

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46616

CERTIFICATE OF DEATH

90

E 46616

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of Baltimore: (No. 335 S Robinson St., 1-2 Ward)

2-FULL NAME Elizabeth Zimmerly

(a) RESIDENCE NO. 335 S Robinson St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 41 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: white

5 Single, Married, Widowed or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Peter Zimmerly

6 DATE OF BIRTH (month, day, and year): Sept 8 1887

7 AGE: Years 41 | Months 8 | Days 28 | IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Home
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer: at home

9 BIRTHPLACE (city or town): Baltimore
(State or country)

PARENTS

10 NAME OF FATHER: Charles Wilson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant: Charles Zimmerly
(Address) 335 S Robinson

15 Filed ....., 19.... Registrar

JUN 7 1929 BALTIMORE CITY

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 6 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Adam Stokes Syndrome

(duration) 1 yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Bleeding 7 hours

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James McFenton, M. D.

6 8 1929 (Address) 7002 Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislaus | DATE OF BURIAL: 6/8 1929

20 UNDERTAKER: J. J. Moan | ADDRESS 3000 E Baltimore

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46617

CERTIFICATE OF DEATH

164 ✓ E 46617

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2049 E. North Ave. ST. 8-17 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Hannah S. Wakeland

(a) RESIDENCE NO. 2049 E. North Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. - mos. - ds. How long in U. S., if foreign birth? - yrs. - mos. - ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

a If married, widowed, or divorced HUSBAND of (or) WIFE of James P. Wakeland

6 DATE OF BIRTH (month, day, and year) July 15, 1842

7 AGE	Years	Months	Days 21	If LESS than 1 day, ... hrs. or ... min.
	86	10	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Harford County (State or country) Maryland

PARENTS

10 NAME OF FATHER John B. McFadden

11 BIRTHPLACE OF FATHER (city or town) Harford Co. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Wann

13 BIRTHPLACE OF MOTHER (city or town) Harford Co. (State or country) Maryland

14 Informant Miss Pearl E. Wakeland

(Address) 2049 E. North Avenue

Filed JUN 7 1929 19

C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June. 6th. 1929

17 I HEREBY CERTIFY, That I attended deceased from June, 19 28, to June 6th, 19 29

that I last saw h 2 alive on June 6th, 19 29

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Infirmities of Age

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. H. Magruder, M. D.

6/6, 19 29 (Address) 14 E. Read St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL 6/10 19 29

20 UNDERTAKER Henry U. Mears & Son

ADDRESS 805 N. Calvert

Please write in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E ~~46618~~ 46618

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

x 13 E 46618

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Isaac Fetterhoff

(a) RESIDENCE No. Elizabethville Pa ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day, and year) ~~December~~

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter 50 05

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER John

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Susan Snyder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUN 7 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7 1929

17 I HEREBY CERTIFY, That I attended deceased from May 7, 1929, to June 7, 1929, that I last saw him alive on June 7, 1929, and that death occurred, on the date stated above, at 4 1/2 A m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs mos 1 ds.

CONTRIBUTORY (Secondary) Paratyphoid typhoid (duration) yrs 6 mos (3) ds.

18 Where was disease contracted if not at place of death? Elizabethville Pa

Did an operation precede death? yes Date of May 1st, 1929

Was there an autopsy? yes, Surgical Pathology May 24, 1929

What test confirmed diagnosis? Blood urea increased

(Signed) Edward Dimmock M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Millersburg Pa DATE OF BURIAL 6/7/29

20 UNDERTAKER Joseph Ahrens ADDRESS 221 Bway

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46619 — 1—PLACE OF DEATH

E 46619 — REGISTERED NO.

CITY OF BALTIMORE: (No. 1343 Mosher ST. 16-25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Gertrude Galloway Follett

(a) RESIDENCE NO. 1343 Mosher ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	M

5a If married, widowed, or divorced (or) WIFE of Step Talbert

6 DATE OF BIRTH (month, day, and year) Sept 6-89

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	39	9		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer Calvert & Co

9 BIRTHPLACE (city or town) (State or country) Calvert & Co

PARENTS

10 NAME OF FATHER Florence Galloway

11 BIRTHPLACE OF FATHER (city or town) (State or country) Calvert Co Md

12 MAIDEN NAME OF MOTHER Lindenmeier

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Step Talbert

(Address) 1343 Mosher

15 Filed ..., 19... C. HAMPSON JONES, M. D. Registrar

JUN 7-1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/6/29

17 I HEREBY CERTIFY, That I attended deceased from Feb 2, 1929, to June 6, 1929

that I last saw h alive on June 5, 1929

and that death occurred, on the date stated above, at 12 45 A m.

The CAUSE OF DEATH* was as follows:

Vulvo - Vaginal Carcinoma

(duration) yrs. 4 mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) B. F. Fletcher, M. D.

6/6, 1929 (Address) 1515 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	June 9 1929
20 UNDERTAKER Jno F. Chesshire	ADDRESS 1100 Mosher

IMPORTANT—Fill in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46620

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St., 4-30 Ward)

2-FULL NAME Joseph W. Knott

(a) RESIDENCE NO. Pikesville, Md St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

E 46620

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec. 3 1890

7 AGE: Years 38 | Months 6 | Days 3 | IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country): Md

PARENTS

10 NAME OF FATHER: Harry Knott

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Md

12 MAIDEN NAME OF MOTHER: Sarah Short

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Md

14 Informant: Mrs. Sarah Knott
(Address) Garrison Forest

15 Filed JUN 7 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 5 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Acute Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Pikesville, Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Miller M. D.

6/7, 1929 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Stebbins-Lemeling

DATE OF BURIAL: 6/8 1929

20 UNDERTAKER: Frank H. Speed

ADDRESS: Pikesville, Md

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46621

CERTIFICATE OF DEATH

188-203

E 46621

1-PLACE OF DEATH Balto City Infirmary

City of Baltimore: (No.) North Point Rd & Wis. Ave (St.) (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Manuel Menendez Garcia

(a) RESIDENCE NO. 3406 E Pratt St (St.) 26 (Ward)

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., If of foreign birth? 10 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	35 (approximated)			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tin Mill Worker
(b) General nature of industry, business, or establishment in which employed (or employer) Steel Wks
(c) Name of employer

9 BIRTHPLACE (city or town) Spain
(State or country)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) unknown

14 Informant Geo. F. Ruth
(Address) 1735 Hanford ave.

15 Filed ..... 19.. C. HAMPTON JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fract Skull - central concussion due to an accident (while riding in rumble seat of an auto driven negligently by Antonio Perez) it the auto
CONTRIBUTORY (Secondary) Collided with telegraph pole overturning & causing the above to be thrown out & injured (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. J. Frain M. D.

6/6 19 29 (Address) 2939 Mt Ebden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	June 8 1929
20 UNDERTAKER	ADDRESS
Geo. F. Ruth	1735 Hanford ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 46622

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46622

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Balto City Hosp

City of Baltimore: (No. North Point Rd & Wire Mill Rd) (Street) (Ward)

2-FULL NAME Antonio Perez

(a) RESIDENCE NO. 3406 E Pratt St St., 26 Ward

(Usual place of abode)

Length of residence in city or town where death occurred ✓ yrs. mos. ds. How long in U. S., if of foreign birth? 18 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day and year) not known

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
26	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tin Worker
(b) General nature of industry, business, or establishment in which employed (or employer) Steel Wks
(c) Name of employer

9 BIRTHPLACE (city or town) Portugal
(State or country)

PARENTS

10 NAME OF FATHER Manuel Perez

11 BIRTHPLACE OF FATHER (city or town) Portugal
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant (Address) George F. Ruth 1735 Hartford Ave

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

Par

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 4 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fract. Skull - Central Concussion Due to auto he was driving (negligently) struck telegraph pole wrecking same & causing his death

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) —

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) G. J. Fraunfelder M. D.

6/7, 1929 (Address) 2939 McElderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	June 8 1929

20 UNDERTAKER George F. Ruth ADDRESS 1735 Hartford Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N 7 - 1929

Spec.—1-12-23—M&T—500 Bks.

E 46623

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46623

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St. Agnes Hospital

CITY OF BALTIMORE: (No. Caton & Wilkens Ave St. 8-17 74 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Katie Boyle

(a) RESIDENCE NO. 1609 Ruttland Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 55 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Maid

(b) General nature of industry, business, or establishment in which employed (or employer): 0/0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland.

PARENTS

10 NAME OF FATHER P Boyle

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER C. O'Neil

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland.

14 Informant: Sister—Mrs. Harry Long.

(Address) 1609 Ruttland Ave

15 6-7-1929 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-6— 1929

17 I HEREBY CERTIFY, That I attended deceased from 6-2, 1929, to 6-6, 1929, that I last saw her alive on 6-6—, 1929, and that death occurred, on the date stated above, at 6 50 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Haemmorage

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Hypertension, Arterio Sclerosis. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? History & Physical Exam.

(Signed) Nicholas N Borrelli M. D.

, 19 (Address) St Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount

DATE OF BURIAL: June 10 1929

UNDERTAKER: Pro-Cathedral

ADDRESS: 1735 Harford Av

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 46624

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46624

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 21-43 124

CITY OF BALTIMORE: (No. 3701 White Ave., Raspeburg St., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME WILLIAM W. ERDMAN

(a) RESIDENCE NO. 3701 White Ave. ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Kate L. Erdman

6 DATE OF BIRTH (month, day, and year) March 18, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Prince Georges (State or country) Maryland

PARENTS

10 NAME OF FATHER Peter G. Erdman

11 BIRTHPLACE OF FATHER (city or town) Balto. Co. (State or country) Maryland

12 MAIDEN NAME OF MOTHER Letitia Weddell

13 BIRTHPLACE OF MOTHER (city or town) County Cork (State or country) Ireland

14 Informant Mrs. Erdman

(Address) 3701 White Ave.

15 Filed 6-7-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5th, 1929

17 I HEREBY CERTIFY, That I attended deceased from January, 1925, to June 5th, 1929, that I last saw him alive on June 5, 1929 and that death occurred, on the date stated above, at 7:45 P. m.

The CAUSE OF DEATH* was as follows:

Tachycardia, Sentrito & Flatulence

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Sentritis & Hepatitis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? 3701 White Av

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Terry Carman, M. D.

6-6-1929 (Address) 1701 N. Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	June 8 1929
20 UNDERTAKER	ADDRESS
Frederick Lansdowne	Fullerton

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46625

CERTIFICATE OF DEATH

E 46625

1—PLACE OF DEATH

REGISTERED NO. 92

CITY OF BALTIMORE: (No. 521 S East Ave ST., 16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elinor Carnes.

(a) RESIDENCE NO. 521 S East Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Ananias Carnes.

6 DATE OF BIRTH (month, day, and year) July 28-1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	10	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Clarke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Dont know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Harry Carnes

(Address) 521 S. East ave

15 [illegible] C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6-1929

17 I HEREBY CERTIFY, That I attended deceased from June 3, 1929, to June 6, 1929, that I last saw h[illegible] alive on June 6, 1929, and that death occurred, on the date stated above, at 1 50 p.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) Gradual yrs. mos. ds.

CONTRIBUTORY (Secondary) Thrombosis of Right Mid cerebral artery

(duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Observation

(Signed) Horace B. Tilton, M. D.

6/6, 1929 (Address) 315 S. Highland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Poplar Cem Warren Md	June 9 1929
20 UNDERTAKER	ADDRESS
John Ullrich	1600 Orleans

N 7-1929

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46626

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46626

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 6739 Youngstown Ave. WARD) 26-37

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph F King

(a) RESIDENCE NO. 6739 Youngstown Ave. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah E King

6 DATE OF BIRTH (month, day, and year) Apr 10. 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	1	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Janitor

(b) General nature of industry, business, or establishment in which employed (or employer) Public School

(c) Name of employer City.

9 BIRTHPLACE (city or town) (State or country) Frederick Md

PARENTS

10 NAME OF FATHER Frederick King

11 BIRTHPLACE OF FATHER (city or town) (State or country) Frederick Md

12 MAIDEN NAME OF MOTHER Mary Bowers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Frederick Md

14 Informant Mrs. Sarah E King

(Address) 6739 Youngstown Ave

15 Filed JUN 7 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6-1929

17 I HEREBY CERTIFY, That I attended deceased from ..... 19..... to ..... 19.....

that I last saw him alive on June 6 19 29

and that death occurred, on the date stated above, at 3 45 a m.

The CAUSE OF DEATH* was as follows:

Paresis

2yrs

CONTRIBUTORY (Secondary) Arterio Sclerosis (duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H Frame M. D.

6/6 19 (Address) 2939 Wilkens Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem

DATE OF BURIAL June 10 19 29

20 UNDERTAKER John Ulrich

ADDRESS 2008 Orleans

Be sure that all items are properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46627

CERTIFICATE OF DEATH

E 46627

1-PLACE OF DEATH

City of Baltimore: (No.) Balt City Hospital St. 16-40 (Ward)

REGISTERED NO. 185

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph A. Goldbricks

(a) RESIDENCE NO. 3420 Ravenwood St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Goldbricks

6 DATE OF BIRTH (month, day, and year) May 8/1867

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
62	61	11	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Wheelwright
(b) General nature of industry, business, or establishment in which employed (or employer) Retired
(c) Name of employer

9 BIRTHPLACE (city or town) Balto md
(State or country)

PARENTS

10 NAME OF FATHER Patrick Goldbricks

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Joseph A Goldbricks
(Address) 3420 Ravenwood ave

15 Filed ... 19... J. HAMPSON JONES, M. ... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry) find that said deceased came to h... death on the day stated above.

The CAUSE OF DEATH* was as follows:
(Cerebral) Apoplexy Cerebral, Hemorrhage due to fall in Cellar striking back of head accident (duration) ... yrs. ... mos. 0 ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) 0 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? 920 Hillcrest Road

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) John M Keaton M. D.

6-8-1929 (Address) 7002 Chase st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Govan	June 8 1929
20 UNDERTAKER John Ulmer	ADDRESS 2008 Orleans

IMPORTANT.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

6-7-1929

Spec.—2-29-28—L. F. S.—500 Bks.

E 46628

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46628

CERTIFICATE OF DEATH

1—PLACE OF DEATH St Joseph Hospital REGISTERED NO. 129

CITY OF BALTIMORE: (No.) Cherokee road ST. (WARD) 1750

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Behm

(a) RESIDENCE NO. 2832 Guilford ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret Behm

6 DATE OF BIRTH (month, day, and year): May 10, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77	0	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Furniture Merchant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland

PARENTS

10 NAME OF FATHER: Otto Behm

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant: Mr. Alfred Behm (Son)

(Address) 404 Northway

15 Filed ....., 19.... Registrar

C. HAMPSON JONES, M. D.

JUN 7-1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 6, 1929

17 I HEREBY CERTIFY, That I attended deceased from 5-24-29, 19..., to 6-6-29, 19..., that I last saw h alive on 6-6-29, 19..., and that death occurred, on the date stated above, at 7, 15 p. m.

The CAUSE OF DEATH* was as follows: Chronic Myocarditis & Chronic Nephritis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary): Uremia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of None

Was there an autopsy? No

What test confirmed diagnosis? Clinical Course

(Signed) J B Hendrix, M. D.

, 19.. (Address) Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery

DATE OF BURIAL: June 10, 1929.

20 UNDERTAKER: Henry Sander & Sons, Inc.

ADDRESS: Baltimore St. & Broadway

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46629

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46629

CERTIFICATE OF DEATH

38

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE (No. 648 Wayne St. 27-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Bessie A. Sye

(a) RESIDENCE NO. 648 Wayne ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem.	Col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Paul Sye

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	45	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Chas. N. Foden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Malta Travers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Paul A. Sye

(Address) 648 Wayne St.

15 Filed JUN 7 1929, 19 E. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/5/29

17 I HEREBY CERTIFY, That I attended deceased from 5/25/, 19 29 to 6/5/, 19 29 that I last saw her alive on 6/5/, 19 29 and that death occurred, on the date stated above, at 1:15 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Probably Indirect (duration) about 6 mos. ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) John Bowley M. D.

6/7, 19 29 (Address) 908 Sharp St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	June 8, 1929
20 UNDERTAKER Mrs Katie R. Williams	ADDRESS 3224 Sefwicker Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 46630 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 46630

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 746 Mc Henry ST. 21-29 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John F. Penn

(a) RESIDENCE NO. 746 Mc Henry ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Helen

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62 yrs.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor 080

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithuania

14 Informant Edward Penn (Address) 746 Mc Henry.

15 Filed C. HAMPSON JONES, M. D. Registrar

Par

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5 1929

17 I HEREBY CERTIFY, That I attended deceased from March, 1929, to June 4, 1929, that I last saw h alive on June 4, 1929, and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) A W Buchner M. D.

6/5, 1929 (Address) 37 S. Stricker St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lowden Park Cemetery — DATE OF BURIAL 6/8 1929

20 UNDERTAKER Chas. B. Kuchausky — ADDRESS 637 S. Paca

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N 7-1929

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46631

CERTIFICATE OF DEATH.

90 **E 46631**

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1128 Homewood ave 10-14 Ward)

2-FULL NAME Margaret E. Reardon

(a) RESIDENCE NO. 1128 Homewood ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 17 / 54

7 AGE: Years 74 | Months 11 | Days 18 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired 69

(b) General nature of industry, business, or establishment in which employed (or employer): Dressmaker

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore Md.

(State or country)

PARENTS

10 NAME OF FATHER: Michael Reardon

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Ireland,

12 MAIDEN NAME OF MOTHER: Ellen Welsh

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Ireland,

14 Informant: Kate Cullen (Sister)

(Address) 1128 Homewood ave

15 JUN 7 1929 C. HAMPSON JONES, M. D., Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 8 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept, 1928, to June, 1929, that I last saw h.. alive on June 8, 1929, and that death occurred, on the date stated above, at 2.20 p m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 4 yrs. ± mos. ds.

CONTRIBUTORY (Secondary)

Senility (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Charles O'Donovan Jr., M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral — Date of Burial: June 8 1929

20 UNDERTAKER: Liston P. Tuscallough — ADDRESS: 2620 St Paul,

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46632

CERTIFICATE OF DEATH.

90 **E 46632**

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Belvedere Road & Ford's Lane St., 26 Ward)

2-FULL NAME Harry L Keller

(a) RESIDENCE NO 4505 Prospect Circle St. Windsor Hills Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Elizabeth J. Keller

6 DATE OF BIRTH (month, day, and year) Nov 11 1871

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	57	6	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Floorman

(b) General nature of industry, business, or establishment in which employed (or employer) Hub,

(c) Name of employer

9 BIRTHPLACE (city or town) Frostburg, (State or country) Md.

PARENTS

10 NAME OF FATHER John Keller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown,

14 Informant F. W. Keller, (Address) 4505 Prospect Circle

Filed C. HAMPSON JONES, M. D. Registrar

Per ARR

N 7-1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/6 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Valvular Disease of Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Chas. Morrison M. D.
(Coroner)

6/7, 1929 (Address) 3532 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery Date of Burial 6/6 1929

20 UNDERTAKER Chas. G. Black ADDRESS 742 W. North Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46633

CERTIFICATE OF DEATH

129 E 46633

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 522 11 Highland ST. 7th 11 WARD)

2—FULL NAME Louisa Graf

(a) RESIDENCE NO. 522 11 Highland Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth 54 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Henry W Graf

6 DATE OF BIRTH (month, day, and year) Sept 27-1863

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
65	65	8	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Mr. Schmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Louisa Carow

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Louisa M. Graf

(Address) 522 N Highland Ave

15 Filed JUN 7-1928, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7th 1927

17 I HEREBY CERTIFY, That I attended deceased from May 4, 1927, to June 7, 1927, that I last saw h alive on June 6, 1927 and that death occurred, on the date stated above, at 1 a m.

The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Bright's Disease (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R. E. Graves, M. D.

June 7, 1927 (Address) 3901 Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	June 9 1927
20 UNDERTAKER	ADDRESS
John C. Miller	473 E Oliver

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

JUN 7-1928

Spec.—2-29-28—L. F. S.—500 Bks.

E 46634

HEALTH DEPARTMENT—CITY OF BALTIMORE

3 N E 46634

CERTIFICATE OF DEATH

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 521 S Ann St ST., 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Leokadya Wierzynska or Wieisner

(a) RESIDENCE NO. 521 S. Ann St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 13 1908

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	20	9	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hand Dipper 086

(b) General nature of industry, business, or establishment in which employed (or employer) Chocalate Product

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Casimier Wierzynski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Sophia Szymanski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Sophia Wierzynska

(Address) 521 S. Ann St.

15 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1929

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1929, to June 6, 1929, that I last saw her alive on June 6, 1929 and that death occurred, on the date stated above, at 1.45 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis pulmonum

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) acute dilatation of the Heart

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? x Ray

(Signed) A. K. A. Lawyer, M. D.

M. 7, 1929 (Address) 2438 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary June 10	1929
20 UNDERTAKER	ADDRESS
J. Hunter Weber	4014 Cheslin

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N 7 - 1929

Cor.—10-10-29—A Co.—100 Bks.

E 46635

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46635

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of Baltimore: (No. South Baltimore General Hospital St., Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Stanislaw ~~Janos~~ Fiksak.

(a) RESIDENCE NO. 2700 Elliott. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 26 yrs. --- mos. --- ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? 26 yrs. --- mos. --- ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, HUSBAND of (~~WIFE~~) Mary Fiksak.

6 DATE OF BIRTH (month, day, and year) January 13, ~~1894~~ 1896

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	33 ~~35~~	4	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Stevedore.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Poland.

PARENTS

10 NAME OF FATHER George Fiksak.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland.

14 Informant Mary Fiksak. (wife)
(Address) 1700 Elliott St.

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

JN7-1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Internal Injuries. Crushed about the body. Accidentally caught under a caving in of a bank of salt on S/S Harburg. (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Pier 9 Locust Point. June 4 1929

Did an operation precede death? Yes. Date of June 4, 1929

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Chas. Kinkaid, M. D.

6/7, 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cem. DATE OF BURIAL June 10 1929

20 UNDERTAKER Stephen J. Fialkowski Inc. ADDRESS 1000 S. Kenwood Ave.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

Dr Schmidt 701 N. Kenwood Ave

E 46636

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44 E 46636

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 505 N Belnord Ave WARD 10)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Theresa Faber

(a) RESIDENCE NO. 505 N. Belnord Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Faber

6 DATE OF BIRTH (month, day, and year) May 15, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78		20 21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Frank Russman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Mary Faber

(Address) 505 N. Belnord Ave

15 Filed JUN 7 1929 C. HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5. 1929

17 I HEREBY CERTIFY, That I attended deceased from April 28, 1929, to June 5, 1929, that I last saw h[er] alive on June 4, 1929, and that death occurred, on the date stated above, at 9 1/2 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach.

CONTRIBUTORY (Secondary) Exhaustion (duration) ? yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Conrad Schmidt, M. D.

June 7, 1929 (Address) 701 N. Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood	June 8 1929

20 UNDERTAKER Wm Cook ADDRESS 1217 St Paul St

JUN 7-1929

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46637

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44 E 46637

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Saint Joseph's Hospital ST.) (WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME August Rak Sr

(a) RESIDENCE NO. 2728 Hampden Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced, HUSBAND of (or) ~~WIFE~~ of Katherine Rak

6 DATE OF BIRTH (month, day, and year) Aug 12/69

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of Industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Joseph Rak

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Katherine Rak

(Address) 2728 Hampden Ave

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

Bur

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/7/29

17 I HEREBY CERTIFY, That I attended deceased from 2/29, 19 29, to 6/7, 19 29, that I last saw him alive on 6/7, 19 29 and that death occurred, on the date stated above, at 4.02 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

CONTRIBUTORY (Secondary) Bronchopneumonia (duration) yrs. mos. ds.

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 6/4/29

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) T. Messina, M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL 6/10 1929

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION necessary important. See instructions on back of certificates.

JUN 7-1929

Spec.—2-29-28—L. F. S.—500 Bks.

E 46638 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001

E 46638

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1719 N. Carey ST. 15-7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edna Mae Green

(a) RESIDENCE NO. 1719 N. Carey ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Mar. 5. 1908

7 AGE — Years: 21 | Months: 3 | Days: | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. md.

PARENTS

10 NAME OF FATHER: Wm. Green

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto md.

12 MAIDEN NAME OF MOTHER: Dellephine Fletcher

13 BIRTHPLACE OF MOTHER (city or town) (State or country): md.

14 Informant: Wm Green

(Address): 1719 N. Carey St.

15 Filed JUN 7 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/5/29

17 I HEREBY CERTIFY, That I attended deceased from June 1 19 29 to June 5 19 29

that I last saw h[illegible] alive on June 5 19 29

and that death occurred, on the date stated above, at 1 p.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

6/6. 19 29 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cemetery — DATE OF BURIAL: June 8 1929

20 UNDERTAKER: Thomas E. Kelson — ADDRESS: 1303 Hoffman St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 46639

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

46 E 46639

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 630 Pitcher St. 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ida Stokes Tutman

(a) RESIDENCE NO. 630 Pitcher St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Robert De S. Tutman Sr.

6 DATE OF BIRTH (month, day, and year) Dec 1, 1877

7 AGE	Years	Months	Days	IF LESS than 1 day ___ hrs. or ___ min.
52	51	6	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer Stevens Station / King Queen Co.,

9 BIRTHPLACE (city or town) Virginia

(State or country)

PARENTS

10 NAME OF FATHER Stokes Johnson

11 BIRTHPLACE OF FATHER (City or town) Va

(State or country)

12 MAIDEN NAME OF MOTHER Cordelia Ann

13 BIRTHPLACE OF MOTHER (city or town) Va

(State or country)

14 Informant Robert De Sherman Tutman Jr

(Address) 2122 Druid Hill Av

15 Filed ... 19...

C. HAMPSON JONES, M. D. Registrar

Per ...

JN 7 - 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5, 1929 19

17 I HEREBY CERTIFY, That I attended deceased from March 2, 1929, to June 5, 1929, that I last saw her alive on June 4, 1929, and that death occurred, on the date stated above, at 2.10 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Asthenia

(duration) yrs. 1 mos. 14 ds.

18 Where was disease contracted ~

if not at place of death?

Did an operation precede death? no Date of ~

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. P. Hughes, M. D.

6/5. 1929 (Address) 825 N. Fremont Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Mt Auburn Cemetery	June 8 1929

20 UNDERTAKER Thomas E. Kelson

ADDRESS 1297 Bressman St

NOTE.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 46640 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 46640

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1386 Woodyear St. 15-23 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Spencer Hill

(a) RESIDENCE NO. 1386 Woodyear ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 28, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
			10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work do

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Namath Hill

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Mamie Hall

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Norman Hill
(Address) 1386 Woodyear

15 Filed . 19 Per C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/6 1929

17

I HEREBY CERTIFY, That I attended deceased from 6/3, 1929, to 6/6, 1929, that I last saw h[illegible] alive on 6/6, 1929, and that death occurred, on the date stated above, at 2 A.M.

The CAUSE OF DEATH* was as follows:

Premature Birth +
Placenta + Gastritis -
(6 or 7 month Birth)

(duration) yrs. mos ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature], M. D.

6/7, 1929 (Address) 239 S. [illegible] a

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL June 8 1929

UNDERTAKER T. E. Pelan [signature]

ADDRESS 1363 Pressman St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

N7-1929

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46641

CERTIFICATE OF DEATH

1855 E 46641

1—PLACE OF DEATH

REGISTERED NO. .....

CITY OF BALTIMORE: (No. Balto. City Hospitals ST. ..... WARD) 14-20

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jennie Waddell

(a) RESIDENCE NO. 1807 Madison Ave ST., ... WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem.	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ? 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER W. W. Holmes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Jane Roan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Record

(Address)

15 Filed JUN 7-1929, 19 C. HAMPSON JONES, M. D. Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/6/29

17 I HEREBY CERTIFY, That I attended deceased from 12/8, 1927, to 6/6, 1929, that I last saw her alive on 6/6, 1929 and that death occurred, on the date stated above, at 11.45 P m.

The CAUSE OF DEATH* was as follows:

Fracture right hip -

(Fall)

..... (duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

..... (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical & X ray

(Signed) Lillie Lampkin, M. D.

6/7, 1929 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary Cem — DATE OF BURIAL 6/10/1929

20 UNDERTAKER Mrs. Geo. H. Holland — ADDRESS 1631 Druid Hill

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 46642 Pronounced dead on arrival

HEALTH DEPARTMENT—CITY OF BALTIMORE
CERTIFICATE OF DEATH

188-103 **E 46642**

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
City of Baltimore: (No.) in front and side of 214 S. Catharine St., Ward 19

2-FULL NAME Elfrida Matzdorf

(a) RESIDENCE NO. 2504 Emerson St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
F	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of None

6 DATE OF BIRTH (month, day, and year) Jan 28-1925

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	4	4	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Raguit
(State or country) Germany

PARENTS

10 NAME OF FATHER Herman Matzdorf

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Katie Henry

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Herman Matzdorf
(Address) 2504 Emerson

15 Filed G. HAMPSON JONES, M. D., Registrar
By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/6 1929

17 I HEREBY CERTIFY, That I took charge of the remains deserbed above, held an inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH was as follows: Fracture Skull - Cerebral Concussion

Truck struck & run over child while coasting in toy wagon in front and side of 214 S. Catharine

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted? side and in front of 214 S. Catharine St yrs. mos. ds.
If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. H. France, M. D.

6/7 1929 (Address) 2939 W Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL 6/8 1929

20 UNDERTAKER Robert Brooks & Son — ADDRESS Calhoun Madison

N8-1929

tion should be carefully supplied. AGE should be stated EXACTLY; PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46643 Pronounced Dead 6-6-29 **E 46643**

CERTIFICATE OF DEATH

1-PLACE OF DEATH Fright Exp Co Premises Fact

City of Baltimore: (No. next to 214 E. Lombard St., 10 Ward)

REGISTERED NO. 86-183

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bertold Schmidt

(a) RESIDENCE NO. 2523 W Lombard St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? 4 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed or Divorced, (write the word): Single

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): May 14 - 1922

7 AGE — Years: 7 Months: Days: 23 22 IF LESS than 1 day hrs. nr min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: none
(b) General naturo of industry, business, or establishment in which employed (or employer): child
(c) Name of employer:

9 BIRTHPLACE (city or town): Essen
(State or country): Germany

PARENTS

10 NAME OF FATHER: Robert Schmidt

11 BIRTHPLACE OF FATHER (City or town):
(State or country): Germany

12 MAIDEN NAME OF MOTHER: Sophia Groman

13 BIRTHPLACE OF MOTHER (City or town):
(State or country): Germany

14 Informant: Robert Schmidt
(Address): 2523 W Lombard

15 Filed 1929 C. HAMPSON JONES, M. D. Registrar
By ACH

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/6 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture Skull - Central Concussion due to being run over by truck while Coasting in toy wagon accidental

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted? Where did accident occur? Lombard St

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) L Frame M. D.

6/7 1929 (Address) 2939 Monument E

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: 6/8 1929

20 UNDERTAKER: Robt Brooks & Son — ADDRESS: Eutaw & Hollins

JN 8 1929

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

E 46644 HEALTH DEPARTMENT—CITY OF BALTIMORE E 46644

CERTIFICATE OF DEATH.

REGISTERED NO. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 714 East Street ST.) 5-8 (WARD)

2-FULL NAME Willie Rayner

(a) RESIDENCE NO. 714 East Street ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Several weeks. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State) Va.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem.

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced (or) WIFE of: Leslie Rayner

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 27 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Herself

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Robert Yates

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Annie Price

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Leslie Rayner

(Address) 641 Elm St. Norfolk

15 JUN 8 - 1929 C. HAMPSON JONES, M.D. Registrar

Ref

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/6/1929

17 I HEREBY CERTIFY, That I attended deceased from 5/17/1929 to 6/6/1929 that I last saw her alive on June 1929 and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Phthisis

I dont Know.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Heart failure about 3

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? I dont Know

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None.

(Signed) E. Mayfield Boyd M. D.

(Address) 8 N. Carrollton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ashburn Cemetery DATE OF BURIAL June 9 1929

20 UNDERTAKER: Chas. N. Johnson ADDRESS 446 N. Carolina Ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46645 HEALTH DEPARTMENT—CITY OF BALTIMORE E 46645

CERTIFICATE OF DEATH

44

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Wm. Johnson

(a) RESIDENCE NO. 604 N. Bethel ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henrietta Johnson

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) La.

PARENTS

10 NAME OF FATHER Primus Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) La. Unknown

12 MAIDEN NAME OF MOTHER Lucy ? La.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Henrietta Johnson

(Address) 604 N. Bethel St.

15 Filed JUN 8-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/16/29

17 I HEREBY CERTIFY, That I attended deceased from 6/1, 19 29, to 6/14, 19 29

that I last saw h.... alive on 6/14, 19 29

and that death occurred, on the date stated above, at 6 P. M.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) E. A. Livingston, M. D.

6/2, 1929 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Osborn Cemetery	June 10 1929
20 UNDERTAKER	ADDRESS
Clinton H. Johnson	716 N. Carolina St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

Massimini

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46646

CERTIFICATE OF DEATH

77 E 46646

1—PLACE OF DEATH (Balto City Hospts) REGISTERED NO.

CITY OF BALTIMORE: (No. (Balto Md ST., 70-7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna Massimini

(a) RESIDENCE NO. 505 (Usual place of abode) Normandy Ave ST., WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Massimini

6 DATE OF BIRTH (month, day, and year) Jan 20 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41	4	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 37

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant (Balto City Hospts) (Address) (Balto Md.

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6--6-29

17 I HEREBY CERTIFY, That I attended deceased from 5-25, 19 29 to 6-6, 19 29

that I last saw her alive on 6-6, 19 29

and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis Chronic Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Wm H Hamm M. D.

6/7, 19 29 (Address) Balto City Hospt

*State the Disease Causing Death, or In deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	June 10 1929
20 UNDERTAKER John F Denny	ADDRESS 715 Light St

IMPORTANT—Fill in all items, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46647

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46647

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. ST 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Barnes

(a) RESIDENCE NO. 1121 Madison Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Robert Barnes

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Georgianna ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Records of
(Address) Baltimore City Hospitals

15 Filed 19 C. HAMPSON JONES, M. D.
Registrar.

N8-1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 31, 1929, to June 6, 1929, that I last saw him alive on June 6, 1929 and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency
Aortic Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hydrothorax, Rt Lung

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Warren H. Wilson, M. D.

6/7/29 19 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Norfolk Virginia	6/8/29 19

20 UNDERTAKER ADDRESS

Randall J. Hundley 5781 Beadle Ave

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46648

CERTIFICATE OF DEATH

#9 E 46648

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3302 Tioga Parkway ST.) 15-58 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Moses G. Gans

(a) RESIDENCE NO. 3302 Tioga Parkway. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha S. Gans

6 DATE OF BIRTH (month, day, and year) April 11, 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	64	1	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Umbrellas Mfg

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cincinnati, Ohio.

PARENTS

10 NAME OF FATHER Isaac Gans

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Eliza Goldwein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. Irving Gans

(Address) 3302 Tioga Parkway

15 Filed JUN 8 - 1929 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7th. 1929.

17 I HEREBY CERTIFY, That I attended deceased from Aug. 25, 1927, to June 7, 1929, that I last saw him alive on June 6, 1929 and that death occurred, on the date stated above, at 3:30 A. m.

The CAUSE OF DEATH* was as follows:

Abdominal Carcinoma
(Kidney attachment)

about 2½ (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of Sept. 16, 1927

Was there an autopsy? no

What test confirmed diagnosis? operation, sign & symptoms

(Signed) J. D. Shemwell, M. D.

June 7, 1929 (Address) 3313 Tioga Parkway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem. DATE OF BURIAL 6/9/ 1929

20 UNDERTAKER David Sondheim ADDRESS 1130 W. Mt. Royal Ave.

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46649

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46649

CERTIFICATE OF DEATH

51

1—PLACE OF DEATH

REGISTERED NO. 16-41

CITY OF BALTIMORE: (No. 4200 Valley View Ave ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Helen L. Siegman

(a) RESIDENCE NO. 4200 Valley View Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. 11 mos. 2 ds. How long in U. S., if foreign birth? yrs. Life mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 25 1926

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
2	11	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Harry Siegman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Gertrude Link

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md

14 Informant: Mr. Harry Siegman
(Address) 4200 Valley View ave.

15 Filed June 8 1929 C. HAMPSON JONES, M. D. Registrar

JUN 8 - 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 7 1929

17 I HEREBY CERTIFY, That I attended deceased from May 31, 1929, to June 7, 1929, that I last saw her alive on June 5, 1929, and that death occurred, on the date stated above, at 3.45 a m.

The CAUSE OF DEATH* was as follows:

Pericarditis.

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Acute Rheumatic Fever

(duration) yrs. mos. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Partial.

What test confirmed diagnosis?

(Signed) D. Hardesty, M. D.

6/7, 1929 (Address) 4810 Belair Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery — DATE OF BURIAL: June 8 1929

20 UNDERTAKER: Henry Hoen & Sons, Inc. — ADDRESS: 1301 E Eager St

IMPORTANT—Fill in all items, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 46650 HEALTH DEPARTMENT—CITY OF BALTIMORE E 46650

CERTIFICATE OF DEATH.

111-091

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1313 Etting (ST.) (WARD) 14-20

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Robinson

(a) RESIDENCE NO. 1313 Etting St (ST.) (WARD)

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Joseph Robinson

6 DATE OF BIRTH (month, day and year) — — 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Lexington Va
(State or country)

PARENTS

10 NAME OF FATHER Sanford Lyle

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Maria Simms

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Joseph Robinson
(Address) 1313 Etting St

15 Filed . 19 C. HAMPSON JONES, M. D.
Registrar

JUN 8 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6. 1929

17 I HEREBY CERTIFY, That I attended deceased from 5/16/29, to 6/6/29, that I last saw her alive on 6/5/29, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Toxic Colon

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Hemorrhoids for some time

duration yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Lee Chis. M. D.

6/7, 1929 (Address) 924 Gladison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Calvery cemetery DATE OF BURIAL: June 9, 29

20 UNDERTAKER: Mrs R.A. Elliott ashland ave ADDRESS: 1725

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 46651

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

+ 84 ~E 46651

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Baltimore & Holliday Sts. Ward) 47

2-FULL NAME Ernest Varden Dudley. Earnest Varden Dudley. Dupt. 7/11-29.

(a) RESIDENCE NO. Silver Spring, Md. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White.	Married.

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Poole Dudley. Poole Dudley.

6 DATE OF BIRTH (month, day, and year) April 24, 1885.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	44	1	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter & Builder
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Goshen, Va.
(State or country)

PARENTS

10 NAME OF FATHER James Dudley.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia.

12 MAIDEN NAME OF MOTHER Henrietta Phillips.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia.

14 Informant Mrs. Poole Dudley. (wife)
(Address) Silver Spring, Md.

15 Filed C. HAMPSON JONES, M. D. Registrar

N8 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7, 1929 92

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris. Occlusion of the right Coronary.

(duration) yrs. 1 mos. 16 ds.

CONTRIBUTORY (Secondary) Cardiac Arhythmia.

(duration) 1 yrs. mos. ds.

18 Where was disease contracted If not at place of death? --

Did an operation precede death? No. Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy & inquiry.

(Signed) Chas. M. Hissman M. D.

6/8 . 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rockville, Md. DATE OF BURIAL June 8 1929

20 UNDERTAKER W. H. Humphrey ADDRESS Rockville Md

NOTE—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46652 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 46652

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3318 Edmondson Ave ST. 16-70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Clarence M. Keister

(a) RESIDENCE NO. 3318 Edmondson Ave ST.

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. WARD

How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary W. Sauer Keister

6 DATE OF BIRTH (month, day, and year) Jan. 14, 1878

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
51	4	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William H. Keister

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary E. Hoffman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Mary W. Keister

(Address) 3318 Edmondson Ave.

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6, 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb 15, 1929, to June 6, 1929, that I last saw h[illegible] alive on June 6, 1929, and that death occurred, on the date stated above, at 12 15 P.m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical & Urinalysis

(Signed) L. A. Ladd, M. D.

19 (Address) 3517 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL 6/8/29 19

20 UNDERTAKER Harry [illegible] 531 [illegible]

ADDRESS

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

NB-1929 AAH

Spec.—2-29-28—L. F. S.—500 Bkz.

E 46653 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46653

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST. 10-14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret Bailey

(a) RESIDENCE NO. Preston & Valley Sts WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

.a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 6 1861

7 AGE — Years: 67 | Months: 11 | Days: 1 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): New York

PARENTS

10 NAME OF FATHER James Bailey

11 BIRTHPLACE OF FATHER (city or town) (State or country):

12 MAIDEN NAME OF MOTHER Anna Meehan

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Little Sisters of the Poor

(Address) Preston & Valley Sts

15 Filed 1929 19 THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/7/29

17 I HEREBY CERTIFY, That I attended deceased from 5/20 1929, to 6/7 1929, that I last saw h alive on 6/6 1929, and that death occurred, on the date stated above, at 3 30 m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) yrs. mos. 2/1 ds.

CONTRIBUTORY (Secondary) Oedema Lungs

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edmund Loss, M. D.

6/8, 19 29 (Address) 1264 Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral — DATE OF BURIAL: June 8 1929

20 UNDERTAKER: Rita Funeral Home — ADDRESS: 914 Fremont Ave

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 46654 HEALTH DEPARTMENT—CITY OF BALTIMORE E 46654

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 3001 W. Garrison Ave ST. 16-67 WARD

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James S. Ross

(a) RESIDENCE. No. 3001 W. Garrison Ave ST. WARD.

(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Beatrice Nilne Ross

6 DATE OF BIRTH (month, day, and year) March 13, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	2	25 26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work General Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Aberdeen Scotland

PARENTS

10 NAME OF FATHER George Ross

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Janet Lindsay

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant (Address) Mrs. James W. Parks 3001 W. Garrison Ave.

15 Filed JUN 8 1929, 19 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8 1929

17 I HEREBY CERTIFY, That I attended deceased from July 27, 1928, to June 8, 1929, that I last saw h[illegible] alive on June 8, 1929, and that death occurred, on the date stated above, at 12.10 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm D. Gilbert M. D.

6/8, 1929 Address 475 E. Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

DATE OF BURIAL June 10 1929

UNDERTAKER Wellington Cook

ADDRESS 1003 West Baltimore St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46655

CERTIFICATE OF DEATH.

E 46655

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Baltimore General Hospital (St.) (Ward)

2-FULL NAME Mr. John G. Murrill

(a) RESIDENCE NO. 2526 Calverton Heights Ave (St.) (Ward)

(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth M. Murrill

6 DATE OF BIRTH (month, day, and year) May 8, 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	80	-	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Wm S. Murrill

11 BIRTHPLACE OF FATHER (city or town) Nelson Co. (State or country) Virginia

12 MAIDEN NAME OF MOTHER A. Mathews

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mr. James Howard Murrill (Address) 2526 Calverton Hgts. Ave.

15 Filed JUN 8 1929, 19 L. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/7/29 19

17

I HEREBY CERTIFY, That I attended deceased from April 4, 1929, to June 7, 1929, that I last saw him alive on June 7, 1929 and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Prostatic hypertrophy (benign)

Chronic nephritis

~~Cerebral hemorrhage~~

Chronic myocarditis (duration) 10 yrs. mos ds.

CONTRIBUTORY ~~(Secondary)~~ ~~Influenza, pneumonia, etc.~~

~~(duration)~~ 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Lab

(Signed) Benjamin Lamb M. D.

6/7, 1929 (Address) West Balt. Gen. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL June 10 19 29

20 UNDERTAKER Wm. H. Cook

ADDRESS 1003 West Baltimore St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46656

CERTIFICATE OF DEATH

129 E 46656

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1818 W. Lanvale St. ST. 16-22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lenurse B. Murray

(a) RESIDENCE NO. 1818 W. Lanvale St. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Louise Murray

6 DATE OF BIRTH (month, day, and year) About 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
About	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Stationery

(b) General nature of industry, business, or establishment in which employed (or employer) Engineer 30

(r) Name of employer

9 BIRTHPLACE (city or town) (State or country) Nelson Virginia

PARENTS

10 NAME OF FATHER John Murray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Rosebud Murray

(Address) 1818 W. Lanvale St.

15 Filed JUN 8 - 1929 G. HAMPSON JONES, M. D. Registrar RRM

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1929 to June 7, 1929

that I last saw him alive on June 4, 1929

and that death occurred, on the date stated above, at 6.21 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Frank H. Oden M. D.

6/7, 1929 (Address) 115 N. Carey St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional spare.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lynchburg, Virginia

DATE OF BURIAL June 9 19 29

20 UNDERTAKER Joseph D Cook

ADDRESS 1003 West Baltimore St

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46657 — E 46657

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 1915 Division St. 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lena E Wilson Mitchell

(a) RESIDENCE NO. 818 N Bond ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Widowed

6 If married, widowed, or divorced (or) WIFE of Wm. Mitchell

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dorchester Co Md

PARENTS

10 NAME OF FATHER John W Hughes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dorchester Co Md.

12 MAIDEN NAME OF MOTHER Fannie Pinder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dorchesterco Md

14 Informant Edw L Wilson (son)

(Address) 1915 Division st.

15 Filed JUN 9 1929 16 HAROLD JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 5 . 1929. to June 7. 1929.

that I last saw h er alive on June 6 . 1929

and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Gastric

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Partial obstruction of Cylorus of Stomach (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical & Laboratory

(Signed) R J Young, M. D.

6/8 . 1929 (Address) 1429 E Monument st

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL June 10 1929

20 UNDERTAKER Theodore White — ADDRESS 823 Wash

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46658

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46658

CERTIFICATE OF DEATH

1—PLACE OF DEATH U. M. H

REGISTERED NO. 49

CITY OF BALTIMORE: (No. ST. 12-49 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Laureano Torres

(a) RESIDENCE NO. 2207 Nebraska ave ST. Tampa Fla WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Josefa Torres

6 DATE OF BIRTH (month, day, and year) July 9, 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	9	30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cigar maker

(b) General nature of industry, business, or establishment in which employed (or employer) Cigar Manufacturer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Spain

PARENTS

10 NAME OF FATHER Juan Torres

11 BIRTHPLACE OF FATHER (city or town) Spain (State or country)

12 MAIDEN NAME OF MOTHER Ramona Lopez

13 BIRTHPLACE OF MOTHER (city or town) Spain (State or country)

14 Informant Laureano Torres Jr.

(Address) Greenleaf apts

JUN 9 - 1929

HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 23, 1929, to June 8, 1929, that I last saw h alive on June 8, 1929, and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of lung right

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of April 30, 1929

Was there an autopsy? Partial

What test confirmed diagnosis?

(Signed) Francis W Sluck, M. D.

. 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Tampa Fla	6/11 1929
20 UNDERTAKER J. F. Lake & Sons	ADDRESS 1318 Eighth

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

46659

CERTIFICATE OF DEATH.

E 46659

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 108 N Bentalou St. (WARD)

2-FULL NAME Ruth Marie Shomber

(a) RESIDENCE No. 108 N Bentalou ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ✓

6 DATE OF BIRTH (month, day, and year): June 8, 1929

7 AGE Years Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Clarence F Shomber

11 BIRTHPLACE OF FATHER (city or town) (State or country): Columbia

12 MAIDEN NAME OF MOTHER: Agnes M Mazzis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Clarence F Shomber

(Address): 108 N Bentalou St

15 Filed JUN 9 1929, 19

C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 8 1929

17 I HEREBY CERTIFY, That I attended deceased from June 8, 19 29, to June 8, 19 29,

that I last saw her alive on June 8, 19 29,

and that death occurred, on the date stated above, at 6.40 a m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(5½ months)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) ✓

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. O'Neill, M. D.

6/8, 19 29 (Address) 108 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Forrest Lawn

DATE OF BURIAL: June 10 19 29

20 UNDERTAKER: John J Cowan & Son

ADDRESS: 901 Hollins

UN9-1929

I. B. WRITE CLEARLY, WITH INDELIBLE INK. THIS BLANK MUST NOT BE FOLDED. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 46660 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 46660

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2109 McCulloh St., 14-59 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laurence O. Brown

(a) Residence No. 2109 McCulloh St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3-SEX: Male

4-COLOR OR RACE: Col

5-Single, ~~Married, Widowed, or Divorced~~, (Write the word.): Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year): July 1, 1908

7-AGE. 20 — 21 yrs. 11 mos. 6 ds. If LESS than 1 day, ...hrs. or....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: Elevator man

(b) General nature of industry, business, or establishment in which employed (or employer): Running elevator

(c) Name of employer: Baltimore Dbo

9-BIRTHPLACE (city or town) (State or Country), Md

PARENTS.

10-NAME OF FATHER: Richard Louis Brown

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER, Clara Dannhart

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Baltimore Md

14-(Informant): Richard Louis Brown

(Address) 2109 McCulloh St

15-

JUN 9 - 1929

HAMILTON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): June 6, 1929

17-I HEREBY CERTIFY, That I attended deceased from May 26 1929 to June 5 1929.

that I last saw h— alive on June 5 1929

and that death occurred, on the date stated above, at 3:10 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Incipient

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. & X. Ray

(Signed) Hamilton Jones M. D.

June 9 1929 (Address) 1334 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn — DATE OF BURIAL, 6-10 1929

20-UNDERTAKER: Byron & Wright — ADDRESS 218 McCulloh St

Should be carefully supplied. NOTE should be written in ink. Exact statement of OCCUPATION is very important. See in plain terms, so that it may be properly classified. instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46661

CERTIFICATE OF DEATH.

161-001

E 46661

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH 419 S. Bond St

City of BALTIMORE: (No. Baltimore Md St. 314 Ward)

2-FULL NAME Marie Hartley

(a) RESIDENCE NO. 419 S. Bond St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 (Single) Married, Widowed, or Divorced. (write the word): single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 8, 1929

7 AGE — Years | Months | Days | IF LESS than 1 day.....hrs. or 30 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER Charles Albert Hartley

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Antonina Sobaszek

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Austria

14 Informant Charles A. Hartley

(Address) 419 S. Bond St

FILED JUN 9-1929

C. HAMPSON JONES, M. D.
Registrar

Per RMC

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8 1929

17 I HEREBY CERTIFY, That I attended deceased from June 8, 1929, to June 8th, 1929, that I last saw h.r alive on June 8, 1929, and that death occurred, on the date stated above, at 11.55 A m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

Is Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W W Grey, M. D.

6/8/, 1929 (Address) 58 W. Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Holy Cross June 9 1929

20 UNDERTAKER — ADDRESS

M. H. E. Dispatch 37 Saml

UNS-1929

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46662

CERTIFICATE OF DEATH.

129 E 46662

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1309 Gremmont) (St. 9-16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. Reynolds

(a) RESIDENCE NO. 309 Gremmont St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Widower.

5a If married, widowed, ~~or divorced~~ HUSBAND of ~~(or WIFE of)~~ Mary E Keene

6 DATE OF BIRTH (month, day, and year) July 19 1856

7 AGE: Years 72 | Months 10 | Days 18 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Govt. Watchman

(b) General nature of industry, business, or establishment in which employed (or employer): U S

(c) Name of employer: Internal Revenue

9 BIRTHPLACE (city or town)

(State or country) Balto.

PARENTS

10 NAME OF FATHER Wm Reynolds

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Alice McCann

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Rose Donegan

(Address) 1309 Gremmont

15 Filed JUN 9-1929 C. HAMPSON JONES, M. D. Registrar

Per RMH.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7th 1929

17

I HEREBY CERTIFY, That I attended deceased from May 1st 1929 to June 7th 1929, that I last saw h~~im~~ alive on June 7th 1929, and that death occurred, on the date stated above, at 1:30 P m.

The CAUSE OF DEATH* was as follows:

Uraemic Coma

(duration) 3 yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary) Interstinal Nephritis

(duration) 7 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Data

(Signed) H G Saunders, M. D.

6-8-1929 (Address) 719 E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral — Date of Burial: June 10 1929

20 UNDERTAKER: Rita Wiedefeld — ADDRESS: 914 Gremmont Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JUN 9-1929

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

Stamps

E 46663

CERTIFICATE OF DEATH

44 2828 Harford

E 46663

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 820 East Preston ST., 9-18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Silas Parker

(a) RESIDENCE NO. 820 East Preston ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Agnes Parker

6 DATE OF BIRTH (month, day, and year) June 3 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	11	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer 6.30

(b) General nature of industry, business, or establishment in which employed (or employer) Union Steel

(c) Name of employer Bldg Company

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Agnes Parker

(Address) 820 E. Preston St

15 Filed ....., 19 ..... Registrar

G. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7 1929

17 I HEREBY CERTIFY, That I attended deceased from April 1, 19 29, to June 7, 19 29

that I last saw he alive on June 6, 19 29

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. 2 mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Apr 7 29

Was there an autopsy? No

What test confirmed diagnosis? Microscope

(Signed) Thos. Fa. Dennis, M. D.

6/8, 19 29 (Address) 2878 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Marys Hamden — DATE OF BURIAL 6/9 19 29

20 UNDERTAKER William Cook — ADDRESS 217 N Paul ex

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46664

CERTIFICATE OF DEATH

E 46664

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2617 Greenmount Ave ST., Ward 46)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary A. McGraw

(a) RESIDENCE NO. 2617 Greenmount ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Thomas H McGraw

6 DATE OF BIRTH (month, day, and year): June 2 1864

7 AGE: Years 64 Months 0 Days 4 If LESS than 1 day, hrs. or min. 1

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Pennsylvania

PARENTS

10 NAME OF FATHER: James Barrett

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Annie Barrett

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Thos. G. McGraw

(Address): 2617 Greenmount

15 Filed JUN 8 1929 19

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 6 1929

17 I HEREBY CERTIFY, That I attended deceased from May 22nd, 1929, to June 6th, 1929,

that I last saw him alive on June 6th, 1929

and that death occurred, on the date stated above, at 1.45 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Arteriosclerosis

(duration) 1 yrs mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam

(Signed) Geo Jurgensen III M. D.

6/8/1929 (Address) 4016 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Joseph Cemetery Texas Md

DATE OF BURIAL: 6/10 1929

20 UNDERTAKER: William Cook

ADDRESS: 1217 St Paul

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Burdine 1517 E. North Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 46665 — **CERTIFICATE OF DEATH** — **E 46665**

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. #2007 Kennedy Ave ST. 6-4-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edna Wesley Smith

(a) RESIDENCE NO. 2007 Kennedy Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emma F.

6 DATE OF BIRTH (month, day, and year): April 4 870

7 AGE — Years: 59 — Months: 2 — Days: 4 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Conductor

(b) General nature of industry, business, or establishment in which employed (or employer): 07

(c) Name of employer: Penn. R. R.

9 BIRTHPLACE (city or town) (State or country): Del.

PARENTS

10 NAME OF FATHER: Isaac J. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Del

12 MAIDEN NAME OF MOTHER: Ruth Summers

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs Emma Smith

(Address) 2007 Kennedy Ave

15 Filed JUN 9 1929 19 HAMPSON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 8, 1929

17 I HEREBY CERTIFY, That I attended deceased from 6/5/29, 19, to 6/8/29, 1929, that I last saw him alive on 6/7/29, 19, and that death occurred, on the date stated above, at 6.30 a. m.

The CAUSE OF DEATH* was as follows:

Bronchio-pneumonia -

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Pulmonary Embolism

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) George A Bauden, M. D.

6/8, 1929 (Address) 1517 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: West Point Penn Lane — DATE OF BURIAL: 1929

20 UNDERTAKER: H. M. Cook — ADDRESS: 12 W 31st St Baltimore

Bur.

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

225870

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46666

CERTIFICATE OF DEATH.

113

E 46666

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. 7-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Kutlik

(a) RESIDENCE NO. 2421 Mc Elderry ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 26-1929

7 AGE: Years | Months: 3 | Days: 11 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER A J

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER Rena Kaplan

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

JUN 8 1929

H. HANSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7 1929

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1929, to June 7, 1929, that I last saw h in alive on June 7, 1929, and that death occurred, on the date stated above, at 11 30 a m.

The CAUSE OF DEATH* was as follows:

Lobo Pneumonia

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Otitis Media

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) V. C. Goodwin M. D.

6/7, 1929 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oakhill Cemetery — DATE OF BURIAL: 6/9 1929

20 UNDERTAKER: Wm Cook — ADDRESS: 1217 ex Paul

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46667

CERTIFICATE OF DEATH

90 E 46667

1—PLACE OF DEATH

REGISTERED NO. 8-16

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2524 E. Hoffman ST. WARD)

2—FULL NAME Ella S. Wagner

(a) RESIDENCE NO. 2524 E. Hoffman ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 66 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph E. Wagner

6 DATE OF BIRTH (month, day, and year) May 5 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	1	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm. Baker

11 BIRTHPLACE OF FATHER (city or town) Copenhagen (State or country) Denmark

12 MAIDEN NAME OF MOTHER Mary Johnson

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant Jos. E. Wagner

(Address) 106 N. Gloucester St

15 Filed JUN 9 1929, 19

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8-1929.

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1929, to June 8, 1929 that I last saw h[illegible] alive on June 7, 1929 and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation & Decompensation

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? None

(Signed) Thos. J. A. Stevens, M. D.

6/8. 1929 (Address) 2578 Hartford Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery — DATE OF BURIAL 6/10 1929

20 UNDERTAKER William Cook — ADDRESS 1217 St Paul

Important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

E 46668 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

E 46668
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1544 Mc Kean (St.) Ave (WARD) 21

2-FULL NAME Rosa Linda Galbreath

(a) RESIDENCE No. 1544 Mc Kean Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred about 75 yrs. 4 mos. 23 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) about Jan 14th 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
about	75	4	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress 069

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Perfect Garment Co

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Samuel Galbreath

11 BIRTHPLACE OF FATHER (city or town) (State or country) Delta Pa

12 MAIDEN NAME OF MOTHER Mary Ann Gilligan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Rosa Linda Galbreath (Address) 1544 Mc Kean

15 Filed JUN 9-1929 C. HAMILTON JONES, Registrar M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1929

17 I HEREBY CERTIFY, That I attended deceased from June 1st, 1929, to June 5th, 1929, that I last saw her alive on June 5th, 1929, and that death occurred, on the date stated above, at 2.25 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 2 yrs. 8 mos — ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) one yrs. 6 mos — ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Eosinophilia & Clinical.

(Signed) Wm J. Kuehn M. D.

6/6, 1929 (Address) 1701 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery DATE OF BURIAL 6/10/1929

20 UNDERTAKER Geo. Weber & Son ADDRESS 2503 Edmondson Ave

Duration should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28 F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46669 — 129 — E 46669

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE (No.) 2121 Ramsay ST. (WARD) 20-69

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emma Hauk

(a) RESIDENCE NO. 2121 Ramsay ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 6 mos. 16 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

If married, widowed, or divorced: HUSBAND of (or) WIFE of Joseph Hauk

6 DATE OF BIRTH (month, day, and year): Feb 22-1866

7 AGE: Years 62 | Months 6 | Days 16 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Charles Haun

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Sophia Bucher

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: John E Hauk

(Address) 2121 Ramsay St

15 Filed: 6-9-29 H. G. HAMPSON JONES, M. D. Registrar

N 9-1529

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 7-29

17

I HEREBY CERTIFY, That I attended deceased from Jan 1 1927 to June 7 1929, that I last saw her alive on June 7 1929 and that death occurred, on the date stated above, at 12 07 8 m.

The CAUSE OF DEATH* was as follows:

Encephalitis Endocarditis
Chronic Interstitial Nephritis
Arteriosclerosis

(duration) 6 yrs. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? Date of

Was there an autopsy? yes

What test confirmed diagnosis? Clinical

(Signed) Norval C Peters, M. D.

6/7/, 19 29 (Address) 2157 Wilkens Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: June 11 19 29

20 UNDERTAKER: F. A. Hilgent — ADDRESS: 1850 N Balto St

IMPORTANT. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 lbs.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46670

CERTIFICATE OF DEATH

E 46670

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 400 / Strathmore Ave WARD) 23rd 55 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Katy Sohl

(a) RESIDENCE NO. 400 / Strathmore Ave ST.

(Usual place of abode) WARD

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if foreign birth? 50 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Sohl

6 DATE OF BIRTH (month, day, and year) June 19 = 1861

7 AGE Years 67 Months 11 Days 18 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) = 37

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country) Germany

10 NAME OF FATHER Ted Schulberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Adelaide Underwater

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Estelle Schottler

(Address) 400 / Strathmore Ave

15 Filed JUN 7 1929 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6th 1929

17 I HEREBY CERTIFY, That I attended deceased from May 15 . 19 29 . to June 6th . 19 29 .

that I last saw h alive on June 6th . 19 29

and that death occurred, on the date stated above, at 9. P. m.

The CAUSE OF DEATH* was as follows:

Endocarditis

Myocarditis

Indefinite (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry Sherman, M. D.

June 19 29 (Address) 268 Wilson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	June 9th 1929
20 UNDERTAKER	ADDRESS
J. A. Neufeldt	1850 W. Baltimore St

important. See instructions on back of certificates.

HARRISON JONES, M. D.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46671

CERTIFICATE OF DEATH

43 E 46671

1—PLACE OF DEATH St Joseph Hospital REGISTERED NO. 9446

CITY OF BALTIMORE: (No. Caroline & ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thomas J Coughlin

(a) RESIDENCE NO. 2701 Fremont St WARD 52
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE: Years 53 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Store Keeper
(b) General nature of industry, business, or establishment in which employed (or employer) Confectionery
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS
10 NAME OF FATHER John Coughlin
11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland
12 MAIDEN NAME OF MOTHER Catherine Cuddy
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant T. J. Coughlin
(Address) 4606 Park Heights Ave

15 Filed JUN 9 1929 H. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-6-29

17 I HEREBY CERTIFY, That I attended deceased from 5-28-29 19 to 6-6-29 19, that I last saw h in alive on 6-6-29, 19, and that death occurred, on the date stated above, at 4 9 m.

The CAUSE OF DEATH* was as follows:

Cancer Tongue (duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Bronco Pneumonia (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 6-5-29

Was there an autopsy? No

What test confirmed diagnosis? Disease

(Signed) J. McHendrick, M. D.

19 (Address) 2 North Hopkins

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery | DATE OF BURIAL: June 10 19 29

20 UNDERTAKER: Margaret S. Flynn | ADDRESS: 1 to 7 Light St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 46672

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 185 ✓ E 46672

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Balt City Hospital St., 1-2 Ward)

2-FULL NAME Elizabeth Winters

(a) RESIDENCE NO. 25 Robinson St., Ward Spruce Pt

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Femal	white	Sing

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 17 [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	2	8	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Spruce Pt
(State or country) Md

PARENTS

10 NAME OF FATHER Harold Winters

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Juanita Co Pa

12 MAIDEN NAME OF MOTHER Mary Morgan

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Philadelphia Pa

14 Informant Mary Winters
(Address) 25 Robinson

JUN 9-1929

C. HAMILTON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jun 7 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture Skull ✗
Lacerated Brain
from Fall from back Porch
accident (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 25 Robinson

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Jno M Rubin M. D.

6/8/1929 (Address) 760 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	June 10 1929
20 UNDERTAKER	ADDRESS
[illegible]	2405 Orleans

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A C.—100 Bks.

E 46673

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

128 V

E 46673

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 837 E Lombard St., 3-5 Ward)

2-FULL NAME John Earley (Farley)

(a) RESIDENCE NO. Shelby P/a St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louise Pitt Earley

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	42			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work unknown
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Shelby
(State or country) Ireland

PARENTS

10 NAME OF FATHER John Earley

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary O'Donnell

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Mrs. A. M. Harris
(Address) 6 Hardwicke Lansdowne

Filed JUN 9 1929, 19..

C. HAMPSON JONES, M. D.
Registrar

By Reed

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 3d 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Acute nephritis

(duration) two mos. yrs. mos. ds.

CONTRIBITORY (Secondary) Chronic alcoholism

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Hinton, M. D.

June 4, 1929 (Address) York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	June 10 1929
20 UNDERTAKER Wm. J. Dickey & Sons	ADDRESS York Rd

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.-7-17-26—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46674 — 92 E 46674

PLACE OF DEATH: Mercy Hospital — REGISTERED NO.

City of BALTIMORE: (No.) St. 16-67 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME: Mrs Laura Waugh

(a) RESIDENCE NO. 3206 Gwynn Falls Pkwy St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: late James Waugh

6 DATE OF BIRTH (month, day, and year): Nov 5. 1874

7 AGE — Years: 54 — Months: 7 — Days: 1 — IF LESS than 1 day ..hrs. or ..min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Balto Md

(State or country)

PARENTS

10 NAME OF FATHER: Mc Laughlin

11 BIRTHPLACE OF FATHER (City or town): unknown

(State or country)

12 MAIDEN NAME OF MOTHER:

13 BIRTHPLACE OF MOTHER (city or town):

(State or country)

14 Informant: Mrs. Mc Laughlin

(Address) 1121 Linden Ave

15 Filed JUN 9 - 1929 — C. HAMPSON JONES, M. D. Registrar — Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6-7-29 19

17 I HEREBY CERTIFY, That I attended deceased from 5-18-'29, 19 to 6-7 1929, that I last saw her alive on 6-7 1929, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Cholecystitis

(duration) 20 (?) yrs. mos. ds.

CONTRIBUTORY (Secondary): Mesenteric Thrombosis

(duration) yrs. 1 mos. 3 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of 5-22-29

Was there an autopsy? No Full Hospital Records

What test confirmed diagnosis? Clinical & operative

(Signed) J. Fugho, M. D.

6-7. 1929 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — Date of Burial: 6/10 1929

20 UNDERTAKER: H Brauning & Son — ADDRESS 1136 Poplar Grove St

U. S.—WHITE PAPER, WITH CARBON, FOR THIS CERTIFICATE. PRINT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46675

CERTIFICATE OF DEATH

24 V

1—PLACE OF DEATH

REGISTERED NO. E 46675

CITY OF BALTIMORE: (No. Sydenham Hospital 811 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mabel Cumbest

(a) RESIDENCE NO. 1209 N. Decker Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. — mos. — ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: James E. Cumbest

6 DATE OF BIRTH (month, day, and year): Oct 10, 1897

7 AGE: Years 31 | Months 7 | Days 28 30 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Prince Anne Md

PARENTS

10 NAME OF FATHER: Solon Dennis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Elizabeth Haynes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: James E. Cumbest

(Address) 1209 N. Decker Ave

Filed JUN 9 1929 HAMPSON JONES, M. D. Registrar

By RLM

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 8, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1929, to June 8, 1929, that I last saw her alive on June 8, 1929 and that death occurred, on the date stated above, at 5 30 a m.

The CAUSE OF DEATH* was as follows:

Meningitis (Meningococcic)

P (duration) 0 yrs. 0 mos. 9 ds.

CONTRIBUTORY (Secondary) Pregnancy (duration) 10 yrs. 8 mos. 0 ds.

18 Where was disease contracted if not at place of death? 1209 N Decker Ave

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical findings & Autopsy

(Signed) Addison Croft Jolly, M. D.

6-9, 1929 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Carmel Cem

DATE OF BURIAL: 6/9 1929

20 UNDERTAKER: William Cook

ADDRESS: 1717 Mt Carmel

IMPORTANT. See instructions on back of certificates. OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very

Spec.—2-29-28—L. F. S.—500 Bks.

E46676 · HEALTH DEPARTMENT—CITY OF BALTIMORE · ✓ 46676

CERTIFICATE OF DEATH · 90 E 46676

1—PLACE OF DEATH · REGISTERED NO. ____

CITY OF BALTIMORE: (No. 1727 Ruxton ave ST. 15-68 WARD) · (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harold L Bonney

(a) RESIDENCE NO. 1727 Ruxton ave ST., ____ WARD (Usual place of abode) · (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. ____ mos. ____ ds. · How long in U. S., if foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	M.

a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence M Bonney

6 DATE OF BIRTH (month, day, and year) Mr 13 1900

7 AGE	Years	Months	Days	If LESS than 1 day, ____ hrs. or ____ min.
	28	6	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manager

(b) General nature of industry, business, or establishment in which employed (or employer) U S Rubbers

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER James E Bonney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Mary Redifer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Mrs Florence L Bonney

(Address) 1727 Ruxton ave

15 Filed JUN 9 1929, 19__. HAMILTON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7 29

17 I HEREBY CERTIFY, That I attended deceased from April 6 19 29 to June 7 19 29

that I last saw him alive on June 7 19 29

and that death occurred, on the date stated above, at 8 m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) 2 yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) 2 yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? ____

Did an operation precede death? ____ Date of ____

Was there an autopsy? ____

What test confirmed diagnosis? Physical Examination

(Signed) W Kellogg M. D.

19 (Address) 2224 W. North

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	June 10 1929
20 UNDERTAKER	ADDRESS
W M Koutson	2233 W North

DO NOT DETACH the plain forms, so that it may be properly classified. Each statement is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46677

CERTIFICATE OF DEATH

101-001

E 46677

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1102 W. Fayette ST. 18-16 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ella A. Tibbals

(a) RESIDENCE NO. 1102 W. Fayette ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. 11 mos. 25 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: Wm. H. Tibbals

6 DATE OF BIRTH (month, day, and year): June 14, 1868

7 AGE — Years: 60 — Months: 11 — Days: 25 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Leonard H. Nolshman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Emily Gerberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Co. Md.

14 Informant: Miss Amy Nolshman

(Address): 1102 W Fayette St.

15 Filed: 10 1929 — C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 9, 1929.

17 I HEREBY CERTIFY, That I attended deceased from June 4, 19 29, to June 9, 19 29, that I last saw her alive on June 9, 19 29 and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Frank M. Ogden, M. D.

, 19 (Address) 115 N. Carey

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	June 12 19 29
20 UNDERTAKER: Robert L. Little	ADDRESS: 1103 E. Lanvale

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46678

HEALTH DEPARTMENT—CITY OF BALTIMORE

109-002

E 46678

CERTIFICATE OF DEATH

1—PLACE OF DEATH — Howard Park · REGISTERED NO. 28-64

CITY OF BALTIMORE: (No. 5211 Bosworth Ave ST. 28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Minnie C Parson

(a) RESIDENCE NO. 5211 Bosworth ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 68 yrs. 8 mos. 21 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	widow

a If married, widowed, or divorced HUSBAND of (or) WIFE of Edgar H. Parson

6 DATE OF BIRTH (month, day, and year) Sept 17 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	8	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Stephen D. Coulbourn

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Emily Dashiell

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Edgar H. Parson
(Address) 2601 Lyndhurst Ave

15 Filed JUN 10 1929, 19 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1929, to June 8, 1929, that I last saw h alive on June 8, 1929 and that death occurred, on the date stated above, at 10 20 m.

The CAUSE OF DEATH* was as follows:

Septicaemia general

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Harry E. Wilson, M. D.

, 19 (Address) 13 W. Biddle

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	June 10 1929
20 UNDERTAKER Chas G. Black	ADDRESS 1420 North Ave

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46679

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46679

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2869 Chesterfield ST. 29-45 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Augusta L. Klein

(a) RESIDENCE NO. 2869 Chesterfield ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Late Louis Klein

6 DATE OF BIRTH (month, day, and year): Sept. 24 1851

7 AGE: Years 57 | Months 8 | Days 13 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Patrick O Shea

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary A Shaw

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Frank Klein

(Address) 2869 Chesterfield ave

15 Filed 6-11-1929 G. HAMILTON JONES, M. D. Registrar

By Ruth

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 7 1929

17

I HEREBY CERTIFY, That I attended deceased from June 30, 1928, to June 7, 1929

that I last saw her alive on June 6, 1929

and that death occurred, on the date stated above, at 7 20 A. M.

The CAUSE OF DEATH* was as follows:

Aortic regurgitation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute dilatation of Heart

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) Albert G Bringhurst M. D.

6/8, 1929 (Address) 1613 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery

DATE OF BURIAL: June 11 1929

20 UNDERTAKER: Geo. F. Ruth

ADDRESS: 1725 Harford ave

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46680

CERTIFICATE OF DEATH

129

E 46680

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1646 Belt St. 24-34 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Flora J. Hale

(a) RESIDENCE NO. 1646 Belt St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank Hale

6 DATE OF BIRTH (month, day, and year): July 31 1877

7 AGE: Years 51 | Months 10 | Days 8 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Pa.

PARENTS

10 NAME OF FATHER: Oliver D. Bannon

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country):

14 Informant: Frank Hale

(Address): 1646 Belt St

15 Filed JUN 10 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6-9-29

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1929, to June 9, 1929, that I last saw h[illegible] alive on June 9, 1929 and that death occurred, on the date stated above, at 12 30 A m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Interstitial

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. O. L. Campbell M. D.

June 9, 1929 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Alexander Va.

DATE OF BURIAL: 6/12 1929

20 UNDERTAKER: I. Flew McCully

ADDRESS: 130 E. Fort

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46681 — **CERTIFICATE OF DEATH** — **E 46681**

1—PLACE OF DEATH

REGISTERED NO. 13-51 31

CITY OF BALTIMORE: (No. 855 W 36th St. ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna Ford

(a) RESIDENCE NO. 855 W 36th St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Stanley Ford

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) md (State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown.

14 Informant Stanley Ford.

(Address) 855 W 36th St.

15 Filed JUN 10 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7, 1929.

17 I HEREBY CERTIFY, That I attended deceased from Feb 1, 1929. to June 7, 1929.

that I last saw h alive on June 7, 1929

and that death occurred, on the date stated above, at 5:10 p. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) yrs. 4 mos. 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Typical symptoms

(Signed) C. F. Culpepper M. D.

6/10 1929 (Address) 3701 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Hampden.

DATE OF BURIAL: June 10 1929.

20 UNDERTAKER: Chesnut & Son

ADDRESS: 3615 Gwynn

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46682

CERTIFICATE OF DEATH

E 46682

REGISTERED NO.

1—PLACE OF DEATH Baltimore City Hospitals

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) ST., 22-30 WARD

2—FULL NAME Andrew Greene

(a) RESIDENCE NO. 620 Perry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1867

7 AGE: Years 62 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Andrew Greene

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Amelia Heuser

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Baltimore City Hospitals

(Address)

Date JUN 10 1929, 19 HAMILTON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 9 1929

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1929 to June 9, 1929.

that I last saw him alive on June 9, 1929

and that death occurred, on the date stated above, at 10-10 a.m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Bony Changes

Senile Home Enlargement (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical findings

(Signed) Harry Goldsmith M. D.

6/9/29 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Marys Hampden	June 11 1929
20 UNDERTAKER	ADDRESS
Chenowith & Son	3615 Eastern Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46683

E 46683

CERTIFICATE OF DEATH

38

1—PLACE OF DEATH: Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 14-28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Ballou

(a) RESIDENCE NO. 1839 W. Baltimore ST., ... WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Annie Ballou

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: I.T. Ballou

11 BIRTHPLACE OF FATHER (city or town) (State or country): Virginia

12 MAIDEN NAME OF MOTHER: Elizabeth Gorgan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Records of

(Address) Baltimore City Hospitals

15 Filed 6-10-1929 HAMILTON JONES, M. D. Registrar

Per ....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 8, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 17, 1929 to June 8, 1929, that I last saw h im alive on June 8, 1929 and that death occurred, on the date stated above, at 2:00 A.m.

The CAUSE OF DEATH* was as follows: Cancerous Myelitis, Luetic

(duration) 13 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no What test confirmed diagnosis? Laboratory test

(Signed) [illegible] M. D.

, 19 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: June 10 1929

20 UNDERTAKER: Harry A Witzke — ADDRESS: 1531 W Fayette St

OF DEATH in plain terms, so that it may be properly classified. Each statement of information important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46684 HEALTH DEPARTMENT—CITY OF BALTIMORE E 46684

CERTIFICATE OF DEATH 129

1—PLACE OF DEATH REGISTERED NO.

CITY OF BALTIMORE: (No. 2252 Linden Ave. St., 14-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Hennie Spandauer

(a) RESIDENCE NO. 2252 Linden Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 12th. 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	0	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, (State or country) Md.

PARENTS

10 NAME OF FATHER Levi Spandauer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Rosa Hutzler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bavaria

14 Informant Mr. A. Spandauer

(Address) 2252 Linden Ave.

15 Filed JUN 10 1929 H. LAMPRECHT, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9th. 1929.

17 I HEREBY CERTIFY, That I attended deceased from Apr 15, 1926, to June 9, 1929.

that I last saw h alive on June 9, 1929

and that death occurred, on the date stated above, at 7.15 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chr Int Nephritis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? no

What test confirmed diagnosis? usual

(Signed) Emma S. Magee, M. D.

6/10, 1929 (Address) The Esplanade Apts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Hebrew Cem.	6/11/ 19 29

20 UNDERTAKER ADDRESS

Leonard Sondheim 17-20 W. Mt. Royal Ave.

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 46685

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46685

CERTIFICATE OF DEATH

24-061

1-PLACE OF DEATH

City of Baltimore: (No. 513 S. Green St. 27-30 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Sarah Baynard.(O)

(a) RESIDENCE NO. 513 S. Green St. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. ---- How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	Widow.

5a If ~~XXXX~~ widowed, of ~~XXXXXX~~ ~~XXXXXXXX~~ (or) WIFE of William Baynard.(O)

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	65	----	----	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Mary Baynard.(O) daughter.
(Address) 513 S. Green St.

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D.
Per ..... Registrar

JUN 10 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Steinhardt, M. D.

6/8, 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel, Cem. — DATE OF BURIAL June 10 1929

20 UNDERTAKER S. W. Colhurst Son — ADDRESS 1400 Druid

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46686

CERTIFICATE OF DEATH

44

E 46686

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1600 E. 28th ST. 4-46 WARD)

2—FULL NAME John W. Hamilton

(a) RESIDENCE NO. 1600 E. 28th ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary L. Hamilton

6 DATE OF BIRTH (month, day, and year) Feb. 25-1881

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	48	3	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kent Co. Md.

PARENTS

10 NAME OF FATHER John L. Hamilton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kent Co. Md.

12 MAIDEN NAME OF MOTHER Emma D. Edwards

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kent Co. Md.

14 Informant Mary L. Hamilton
(Address) 1600 E. 28th St.

15 June 10 1929 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7-1929

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1929 to June 7, 1929 that I last saw h— alive on June 7, 1929 and that death occurred, on the date stated above, at 6.30 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Throat (Tonsil + Soft Palate etc)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical + Lab.

(Signed) Kyle W. Bolley, M. D.

(Address) 5103 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	June 10 1929

20 UNDERTAKER George W. Zirkler

ADDRESS 1737 E. Eager st

IN OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46687

CERTIFICATE OF DEATH.

3-4 | 29

E 46687

REGISTERED NO.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 136 S. Bond ST. ..... WARD)

2-FULL NAME Adeline Payne

(a) RESIDENCE No. 136 S. Bond ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	colored	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	59			
	58			

8 OCCUPATION OF DECEASED House Work

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Louis Payne

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Minna Lovelace

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) 136 S. Bond st Mary Payne

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

JUN 10 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8 1929

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1929 to June 8, 1929.

that I last saw her alive on June 7, 1929.

and that death occurred, on the date stated above, at 6-55 p.m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) —

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clin Diag.

(Signed) Frank E Wagner M. D.

6/10, 1929 (Address) 1006 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvery

DATE OF BURIAL June 10 1929

20 UNDERTAKER Edward Bryan

ADDRESS 631 Druid st

Spec.—1-12-23—M&T—500 Bks.

46688

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 46688

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hospital WARD 15-59

2-FULL NAME Mrs Marie Weems

(a) RESIDENCE No. 2340 McCulloh ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of E. J. Weems

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
52	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Husband

(Address) 2340 McCulloh

15 Filed JUN 10 1929

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/8/29 19

17 I HEREBY CERTIFY, That I attended deceased from June 3, 1929, to June 8, 1929, that I last saw her alive on June 8, 1929, and that death occurred, on the date stated above, at 4.30 A m.

The CAUSE OF DEATH* was as follows: Hypertensive Cardio-Vascular Renal Disease with Cardiac Decompensation

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Anemia.

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis? —

(Signed) George McDonald M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rockey Hill Md.

DATE OF BURIAL 6/10/1929

20 UNDERTAKER Mrs. Geo H. Holland

ADDRESS 1631 Druid Hill

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46689 — CERTIFICATE OF DEATH — E 46689

X 100-001

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 4-30 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles L. Frampton

(a) RESIDENCE NO. Royal Oak ST., WARD Talbot Co. Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 25 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Leonard Frampton

6 DATE OF BIRTH (month, day, and year) Mar. 8, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	3	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John W. Frampton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Chambers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Hospital Recorder

(Address)

15 JUN 10 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/9/29

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1929, to June 9, 1929, that I last saw him alive on June 9, 1929, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Benign Hypertrophy of Prostate Gland with Chronic Urinary Retention

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 6/6/29

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Luther C. Peter, M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Easton, Md.	June 10 1929
20 UNDERTAKER	ADDRESS
J. Henry W. Mearsdon	805 N. Calvert St.

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46690

CERTIFICATE OF DEATH.

E 46690

REGISTERED NO. ..

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital ST. WARD)

2-FULL NAME Thomas Jordan

(a) RESIDENCE NO. 2115 E. Chase ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced. (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Katherine E Jordan

6 DATE OF BIRTH (month, day, and year) Aug 30-1879

7 AGE 49 Years 50 Mo 9 Days 8

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Thomas W. Jordan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Mary Grant

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Katherine E Jordan

(Address) 2115 E. Chase St.

15 Filed , 19

Registrar HAMPSON JONES, M. D.

UN 10 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7 1929

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1929, to June 7, 1929.

that I last saw him alive on June 7, 1929.

and that death occurred, on the date stated above, at 10.00 a.m.

The CAUSE OF DEATH* was as follows:

Acute Lasting dilatation

Acute Cardiac dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of June 3, 1929

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Samuel J. Hankin M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery — DATE OF BURIAL June 10 1929

20 UNDERTAKER Wm E Miller & Son — ADDRESS 2384 Jeff St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

E 46691

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45

E 46691

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Church Home & Hosp. St. 1 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Johannah Canoles

(a) RESIDENCE NO. 1804 Aisquith St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 4y yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX f

4 Color or Race w

5 Single, Married, Widowed, or Divorced, (write the word) widow

5a If married, widowed, or divorced (or) WIFE of Thomas Canoles.

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE Years 58 Months Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Frederick Nolte

11 BIRTHPLACE OF FATHER (city or town) Germany

(State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) Not Known

(State or country)

14 Informant Louise M. Bauman

(Address) 1101 E. Eager St.

15 Filed JUN 10 1929 (19) HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/7/29 19

17 I HEREBY CERTIFY, That I attended deceased from 5/19 1929, to 6/7 1929, that I last saw h[illegible] alive on 6/7 1929, and that death occurred, on the date stated above, at 11.50 p.m.

The CAUSE OF DEATH* was as follows:

Toxemia Sepsis

adynamia ileus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) carcinoma rectum

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 5/20/29

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Ronald A Cox, M. D.

, 19 (Address) Church Home, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Loudon Park Cemetery June 12 1929

20 UNDERTAKER ADDRESS

Wm. C. Trilla & Son 2334 E. Monument St.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 46692

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46692

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1040 Homewood Ave St. 10-14 Ward)

2-FULL NAME Michael F. Cassidy

(a) RESIDENCE NO. 1040 Homewood Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 74 yrs. mos. ds.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Elizabeth Cassidy

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
about 61			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none 0
(b) General nature of industry, business, or establishment in which employed (or employer) Former Laborer
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Patrick Cassidy

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Susan McCabe

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto., Md.

14 Informant Mrs Elizabeth Cassidy
(Address) 1040 Homewood Ave

15 Filed JUN 10 1929 WILLIAM H. JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Chr Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Collins M. D.

6/10/29 192 (Address) 500 E. North Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cemetery Taylor Ave

DATE OF BURIAL June 12 29

20 UNDERTAKER Henry Hoe & Sons, Inc.

ADDRESS 1301 E Eager St

Spec.—1-10-21—M&T—1500 Bks.

E 46693 47 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 31 E 46693

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 25-32 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benson Slaughter

(a) RESIDENCE NO. 2514 Ridgely St Mt Winans ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: B

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 23, 1928

7 AGE — Years: — Months: 10 — Days: 14 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... (State or country) Md

PARENTS

10 NAME OF FATHER Horace

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Va

12 MAIDEN NAME OF MOTHER Isabel Harris

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Va

14 Informant ..... Records
(Address) .....

15 Filed JUN 10 1929. C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb 16, 1929, to June 6, 1929, that I last saw him alive on June 6, 1929, and that death occurred, on the date stated above, at 11 55 P m.

The CAUSE OF DEATH* was as follows:

Tuberculous meningitis

(duration) ..... yrs. mos 24 ds.

CONTRIBUTORY (Secondary) Pulmonary tbc

(duration) ..... yrs. 3 mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? Lumbar puncture

(Signed) E. C. Goodwin, M. D.

6/7, 1929 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Auburn — DATE OF BURIAL: June 10 1929

20 UNDERTAKER: Joseph A. Lively — ADDRESS: 4098 W Northst

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 46694

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46694

CERTIFICATE OF DEATH ~~STILL BIRTH~~

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Weloff

(a) RESIDENCE NO. 1129 Somerset ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~~11~~ yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Child

6 DATE OF BIRTH (month, day, and year): June 10, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: John M. Weloff

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Regina M. Faust

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant: John M. Weloff
(Address): 1129 Somerset St.

15 Filed JUN 10 1929 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/9/29

17

I HEREBY CERTIFY, That I attended deceased from 6/7/, 1929, to 6/9/, 1929, that I last saw him alive on 6/3/, 1929, and that death occurred, on the date stated above, at 1.20 a m.

The CAUSE OF DEATH* was as follows:

Planter Cervix

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Prematurity (duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of 6/9/29

Was there an autopsy? Yes

What test confirmed diagnosis? Path

(Signed) J. J. Cadigan, M. D.

, 19 (Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	June 10 1929
20 UNDERTAKER: Elmer W. Conklin	ADDRESS: 924 E. Eager St.

Important. See instructions on back of certificates.

Penalty for making any false statement in this certificate is fine or imprisonment, or both, according to the degree of the offense, as provided by law.

Spec.—1-10-21—M&T—1500 Bks.

225-924

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46695

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

3-5 113 E 46695

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., WARD)

2-FULL NAME Joseph Palumbo

(a) RESIDENCE No. 1113-E. Pratt St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): 2/28/1929

7 AGE: Years — Months: 3 — Days: 10 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): USA

PARENTS

10 NAME OF FATHER: Joseph Palumbo

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Catherine Gallio

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: Friends

(Address) JOHNS HOPKINS HOSPITAL

15 C. HAMPSON JONES, M. D.

Registrar

JUN 10 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 8 1929

17 I HEREBY CERTIFY, That I attended deceased from June 3, 1929, to June 8, 1929, that I last saw him alive on June 8, 1929, and that death occurred, on the date stated above, at 11 40 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia (Bronchial)

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Diarrhoea

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys exam

(Signed) C. C. Goodpasture, M. D.

6/8, 1929 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: 6/10 1929

20 UNDERTAKER: George Ruth — ADDRESS: 1730 Harford Ave

mation should be carefully supplied. AGE should be stated EXACTLY. FIRSTNAME and SURNAME CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46696

CERTIFICATE OF DEATH

129

E 46696

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Maud Barnhart

(a) RESIDENCE NO. 1631 N. Wolfe ST., ... WARD
(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? — yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Barnhardt

6 DATE OF BIRTH (month, day, and year) 2/11 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	47	3	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) ? Md.

PARENTS

10 NAME OF FATHER Harry Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) ? Md.

12 MAIDEN NAME OF MOTHER Mary Parker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ? Md.

14 Informant Records of (Address) BALTIMORE CITY HOSPITALS

15 Filed 6, 19 HAMPSON Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-8-29

17 I HEREBY CERTIFY, That I attended deceased from 5-1, 1929, to 6-8, 1929.

that I last saw her alive on 6-8, 1929

and that death occurred, on the date stated above, at 11:30 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis, chronic

Myocarditis, " Acute

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Pericarditis effusion

(duration) ..... yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Physical, Lab, Tuberculosis

(Signed) Marvin W. H. Gear, M. D.

6-9, 19 29 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — DATE OF BURIAL 6/11 1929

20 UNDERTAKER George & Ruth — ADDRESS 1730 Bedford Avenue

UN 101929

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46697

CERTIFICATE OF DEATH

E 46697

1—PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 509 S. Milton ST. 1-3 WARD)

2—FULL NAME Mary Jaczynska

(a) RESIDENCE NO. 509 S. Milton ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 0 mos. 0 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	68	0	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): At Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Martin Michalak

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Anna Jaczynska

(Address) 509 S. Milton

15 Filed JUN 10 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 8, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 7, 1929, to June 8, 1929

that I last saw h[illegible] alive on June 8, 1929

and that death occurred, on the date stated above, at 3.30 p m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pancreas causing Obstruction of Bile duct

Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Eudgen Kunsowski, M. D.

6/10, 1929 (Address) 2079 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary

DATE OF BURIAL: 6/11 1929

20 UNDERTAKER: Wm. Fiaschetti

ADDRESS: 168 Eastern Ave

Please write plainly, as what is here written is properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

Coggins ✓

E 46698 HEALTH DEPARTMENT—CITY OF BALTIMORE E 46698

CERTIFICATE OF DEATH

141

1—PLACE OF DEATH St. Joseph's Hosp. REGISTERED NO.

CITY OF BALTIMORE: (No. 12-50 ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Gertrude A. Coggins

(a) RESIDENCE NO. 419 Whitridge Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 29 yrs. Lifetime mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White.	Married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 26-1899

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
30	40	—	14 13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sales Lady 061

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Geo W. Trumbo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Margaret Spellman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Ella Scriven

(Address) 419 Whitridge ave

15 Filed JUN 1 - 1929

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 1-1929

17 I HEREBY CERTIFY, That I attended deceased from ....., 19....., to ....., 19.....

that I last saw h... alive on ....., 19.....

and that death occurred, on the date stated above, at 5.55 a.m.

The CAUSE OF DEATH* was as follows:

.....

.....

.....

..... (duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) ....., M. D.

....., 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	June 4 1929

20 UNDERTAKER ADDRESS

Chas. P. Crawford 1100 W. Fayette

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

22368 5

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 46699

E 46699

REGISTERED NO. 100-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Booze

(a) RESIDENCE NO. 1120 Linden Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 21 1928

7 AGE Years 1 Months 0 Days 18 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md —
(State or country)

PARENTS

10 NAME OF FATHER William Booze

11 BIRTHPLACE OF FATHER (city or town) Md —
(State or country)

12 MAIDEN NAME OF MOTHER Nancy Carrick

13 BIRTHPLACE OF MOTHER (city or town) U-C —
(State or country)

14 Informant Friends —
(Address)

Filed JUN 10 1929 19 C. HAMPSON JONES, M. D.
Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7 1929

17 I HEREBY CERTIFY, That I attended deceased from March 23. 1929. to June 7. 1929.

that I last saw him alive on June 7. 1929.

and that death occurred, on the date stated above, at 3 20 P.M.

The CAUSE OF DEATH* was as follows:

Pneumococcus Meningitis

(Broncho pneumonia 10 days last)

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Oldempyema & pneumonia

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? Pneum. at home - Meningitis in hosp.

Did an operation precede death? Yes. Date of 3-21-29

Was there an autopsy? Yes —

What test confirmed diagnosis?

(Signed) H. C. Goodwin, M. D.

6/8, 1929 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL JUN 11 1929

20 UNDERTAKER

ADDRESS

JOHNS HOPKINS HOSPITAL

Commissioner of Health

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should use CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46700 HEALTH DEPARTMENT—CITY OF BALTIMORE E 46700

CERTIFICATE OF DEATH

31

1—PLACE OF DEATH REGISTERED NO.

CITY OF BALTIMORE: (No. 1124 E. Lombard ST. 3-5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Laurence Gross

(a) RESIDENCE NO. 1124 E. Lombard ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elezebth Gross

6 DATE OF BIRTH (month, day, and year) 1897

7 AGE: Years 32 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Gross

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Minnie Henson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Elezebth Gross
(Address) 1124 E Lombard St

15 Filed JUN 10 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8, 1929

17 I HEREBY CERTIFY That I attended deceased from May 31, 1929, to June 8, 1929, that I last saw h[illegible] alive on June 8, 1929, and that death occurred, on the date stated above, at 1.30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) B. F. Jones, M. D.

6/9, 1929 (Address) 38 S Carlton St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Calvery Cem.	6-11 1929
20 UNDERTAKER	ADDRESS
Byron & Knight	1218 McElderry St

OF DEATH in plain terms, so that it may be properly classified. Each question is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46701

CERTIFICATE OF DEATH

101-001-V

101 E 46701

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1166 Cleveland ST. 21-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jacob D Kotmair

(a) RESIDENCE NO. 1166 Cleveland ST.. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divoreed HUSBAND of (or) WIFE of Mary J Kotmair

6 DATE OF BIRTH (month, day, and year) June 2 1856

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or.....min.
73	0	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Glass Packer

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer Swandell Co.

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Philip Kotmair

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Northburger Grandlemeyer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Mary J. Kotmair

(Address) 1166 Cleveland St

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-8-1929

17

I HEREBY CERTIFY, That I attended deceased from 5-27-29, 19 29, to 6/8/29, 19 29.

that I last saw h— alive on 6/8/29 19

and that death occurred, on the date stated above, at 5.20 P m.

The CAUSE OF DEATH* was as follows:

Chr Diff. Nephr

(duration) uncertain yrs. mos. ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 2 days.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Bernard J. Fang, M. D.

6/10/29, 19 (Address) 4 o W. Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral — DATE OF BURIAL 6-11 19 29

20 UNDERTAKER Bernard C Hale — ADDRESS 1000 N Paca St

OF DEATH in plain terms, so that it may be properly classified. Be sure to answer all questions. Every question is important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 46702

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46702

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital. ST. WARD 25-72 161

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Weitzell

(a) RESIDENCE No. 2129 Langley Av. Mt. Winans WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 27, 1929

7 AGE — Years: — Months: — Days: 2 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Mildred Weitzell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs. Weitzell

(Address) Johns Hopkins Hospital

15 Filed 4/30 1929

16 C. HAMPSON JONES, M. D. Registrar

Per RRH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 29 1929

17 I HEREBY CERTIFY, That I attended deceased from April 27, 1929, to April 29, 1929, that I last saw him alive on April 29, 1929, and that death occurred, on the date stated above, at 11.00 A m.

The CAUSE OF DEATH* was as follows:

Prematurity.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Alan Brachman, M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

JOHNS HOPKINS HOSPITAL JUN 10 1929

4/30 1929

INSTRUCTIONS. This certificate should be correctly supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 46703 HEALTH DEPARTMENT—CITY OF BALTIMORE E 46703

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., (WARD) 8-17

REGISTERED NO. 161-08

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ruth Walter

(a) RESIDENCE NO. 1806 E. Eutaw WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	—

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md —

PARENTS

10 NAME OF FATHER Frederick Walter

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Worthy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) —

14 Informant Records — (Address)

15 Filed C. HAMPSON JONES, M. D. Registrar

By [illegible]

N 101329

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6 1924

17 I HEREBY CERTIFY, That I attended deceased from June 6 1924 to June 6 1924.

that I last saw her alive on June 6 1924.

and that death occurred, on the date stated above, at 4:35 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. C. Goodwin M. D.

6/7 1924 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

JOHNS HOPKINS HOSPITAL JUN 10 1924

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46704

CERTIFICATE OF DEATH

E 46704

90

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1503 N. Wolfe St. 8-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Street

(a) RESIDENCE NO. 1503 N. Wolfe St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? 42 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or WIFE of)~~ Enoch Turner Street

6 DATE OF BIRTH (month, day, and year) Sept 22 1861

7 AGE Years 67 Months 8 Days 19 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carp. & Cab.

(b) General nature of industry, business, or establishment in which employed (or employer): 616

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): England.

PARENTS

10 NAME OF FATHER Wm Street

11 BIRTHPLACE OF FATHER (City or town) (State or country): England

12 MAIDEN NAME OF MOTHER Caroline Carr

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant Mrs. Enoch T. Street

(Address) 1503 N. Wolfe

15 Filed ..... C. HAMPSON JONES, M. D. Registrar

(Sgn) .....

N 101929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10, 29 19

17 I HEREBY CERTIFY, That I attended deceased from Apr. 3, 29 to June 10 29, that I last saw him alive on June 9, 29, and that death occurred, on the date stated above, at 12 30 a m.

The CAUSE OF DEATH* was as follows:

Aortic Stenosis & Insufficiency with Dilatation & Hypertrophy

(duration) ..... yrs. 2 mos. 2 ds.

CONTRIBUTORY (Secondary) Myocarditis Chronic Interstitial Nephritis

(duration) ..... yrs. ..... mos. 10 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Auscultation

(Signed) E. Hampson, M. D.

6/10, 1929 (Address) 1005 N. Monroe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery — Date of Burial 6/12 19 29

20 UNDERTAKER Wellman Cook — ADDRESS Mt & Paul

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

(Paul Nork)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46705 90 E 46705

CERTIFICATE OF DEATH

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 3-E WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Paul Nork

(a) RESIDENCE NO. 123 S Spring ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if foreign birth? 7 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unkn ? 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	52	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) ? Russia

PARENTS

10 NAME OF FATHER Danilo Nork ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Russia

12 MAIDEN NAME OF MOTHER Tadia ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Russia

14 Informant Records of (Address) BALTIMORE CITY HOSPITALS

15 C. HAMPSON JONES, M. D. 19 1929 Registrar

N 101929

important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-9-29

17 I HEREBY CERTIFY, That I attended deceased from 6-7, 19 29, to 6-9, 19 29,

that I last saw h.. alive on 6-9, 19 29

and that death occurred, on the date stated above, at 3:20 m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic & acute,
a Pneumococcemia

(duration) 2 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Course

(Signed) BALTIMORE CITY HOSPITALS, M. D.

6-9, 19 29 (Address) Marvin M McLean

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Russian Independent	June 11 1929
20 UNDERTAKER	ADDRESS
John M Weber	401 N Chester St

Cor.—10-10-29—A Co.—100 Bks.

E 46706

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

40 E 46706

1-PLACE OF DEATH

City of Baltimore: (No. Hopkins Hospital St. 14-72 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm. Thomas

(a) RESIDENCE NO. 1615 McCullough St St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred ✓ yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	B	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mch 1/1908

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	21	3	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cook
(b) General nature of industry, business, or establishment in which employed (or employer) 0
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Lancaster Co., Va.

PARENTS

10 NAME OF FATHER Henry Thomas

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Frannie Jordon

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Lavoss Taylor (sister)
(Address) 1615 McCullough St

15 Filed ..., 19.. C. HAMPSON JONES, M. D. Registrar

JUN 10 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inq iry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inq iry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Bacterial Endocarditis

(Probably Gonnococcal)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes at Hopkins

What test confirmed diagnosis?

(Signed) [signature] M. D.

6/10/29 (Address) 505 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lancaster Va	6-11 1929
20 UNDERTAKER George P. A. Gibson	ADDRESS 1733 Druid Hill Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46707 CERTIFICATE OF DEATH 90 **E 46707**

1—PLACE OF DEATH

REGISTERED NO. .....

CITY OF BALTIMORE: (No. 136 East Gettysburg ST. 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary L. Stunner

(a) RESIDENCE NO. 136 E. Gettysburg WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 Single, Married, Widowed, or Divorced, (write the word) Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of Conrad.

6 DATE OF BIRTH (month, day, and year) May 16 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	76		22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Schaffer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wilson

14 Informant August Stunner

(Address) 136 E. Gettysburg

Filed ..., 19 ... HAMILTON JONES, M. D. Registrar

JUN 11 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8 - 1929

17 I HEREBY CERTIFY, That I attended deceased from March 3, 1929, to June 8, 1929.

that I last saw h[illegible] alive on June 8, 1929

and that death occurred, on the date stated above, at 7.45A m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C. B. Wheeler, M. D.

6/11, 1929 (Address) 1209 Millman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Holy Cross Cemetery	6/11 1929
20 UNDERTAKER William Cook	ADDRESS 1275 Penn

IMPORTANT—Fill in all items, so that it may be properly classified. Print plainly in ink. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46708

CERTIFICATE OF DEATH

38 E 46708

1—PLACE OF DEATH

CITY OF BALTIMORE; (No. 123 W Perry ST. 22-30 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Simon O'Mara

(a) RESIDENCE NO. 123 W Perry ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	Col.	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Emma O'Mara

6 DATE OF BIRTH (month, day, and year) July 21 1865

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
63	64	6	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer Gt

(b) General nature of industry, business, or establishment in which employed (or employer) Planedore

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia (Balt)

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia Balt

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia Balt

14 Informant Emma O'Mara
(Address) 123 W. Perry St.

15 Filed ... 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/8/29

17 I HEREBY CERTIFY, That I attended deceased from 5/10/, 19 29, to 6/8/, 19 29, that I last saw h... alive on 6/8/, 19 ..., and that death occurred, on the date stated above, at 5:20 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

8

2 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) 1 yr mos. ds.

18 Where was disease contracted if not at place of death? none

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical microscopic

(Signed) C. Bramhall Bowley, M. D.

19 (Address) 908 N Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	June 12 19 29
20 UNDERTAKER John H. Toadvine	ADDRESS 1027 Pennsylvania Ave

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46709 — CERTIFICATE OF DEATH — E 46709

REGISTERED NO.

1—PLACE OF DEATH Emerg. Hosp.

CITY OF BALTIMORE: (No.) Ellicott City ST. (WARD) 4-30

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Catherine Covey

(a) RESIDENCE NO. University Hospital ST., WARD Ellicott City

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. 20 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Covey

6 DATE OF BIRTH (month, day, and year) March 18, 1872

7 AGE Years 57 | Months 2 | Days 23 24 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER James Healey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Cassandra Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Samuel Covey

(Address) Ellicott City Md

15 Filed JUN 11 1929, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 22, 1929, to June 11, 1929, that I last saw h— alive on June 11, 1929, and that death occurred, on the date stated above, at 2:45 A m.

The CAUSE OF DEATH* was as follows:

Acute cholecystitis.

(duration) yrs. mos. 23 ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs. mos. 23 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? yes Date of May 24, 1929

Was there an autopsy? no Diagnosis of Gall Bladder

What test confirmed diagnosis? Physical Examination

(Signed) Henry Timms Davis, M. D.

6-11, 1929 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem. | DATE OF BURIAL June 13, 1929

20 UNDERTAKER Easton Sons | ADDRESS Ellicott City

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 46710

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46710
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Franklin Square Hospital
CITY OF BALTIMORE: (No. 111-001 ST. 21-29 WARD)

2-FULL NAME William J. Lenard

(a) RESIDENCE No. 1210 Washington Blvd. WARD
(Usual place of abode)
Length of residence in city or town where death occurred 39 yrs. 4 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mary b Lenard.

6 DATE OF BIRTH (month, day, and year) Jan 18th 1890

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
39	4	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor.

(b) General nature of industry, business, or establishment in which employed (or employer) /

(c) Name of employer Bartlett Hayward Co

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Samuel Lenard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Bridget Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Mary C Lenard
(Address) 1210 Washington Blvd.

15 Filed JUN 11 1929

16 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-8 1929

17 I HEREBY CERTIFY, That I attended deceased from 5-19, 1929, to 6-8, 1929, that I last saw h living on 6-8, 1929, and that death occurred, on the date stated above, at 8 30 P. m.

The CAUSE OF DEATH* was as follows:

Ruptured Gastric ulcer

(duration) 3 yrs. 8 mos ds.

CONTRIBUTORY (Secondary) Secondary Lymphosarcoma from ulcer (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 5-14-29

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) C. W. Peake M. D.

, 19 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL June 12 1929.

20 UNDERTAKER John J Howard & Son

ADDRESS 901 Howard St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46711

CERTIFICATE OF DEATH

90

E 46711

1—PLACE OF DEATH St Joseph's Hospital

CITY OF BALTIMORE: (No. Caroline & River ST., 9-18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Mack

(a) RESIDENCE NO. 1836 Hope St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 14-1908

7 AGE — Years: 20 | Months: 11 | Days: 26 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Shipping Clerk

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Balto Bargain House

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Charles E McGrath

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Minnie Diggles

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Minnie Mack (Address) 1836 Hope street

15 Filed ..., 19... HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16, 1929

17

I HEREBY CERTIFY, That I attended deceased from April 17, 1929, to June 16, 1929, that I last saw him alive on June 10, 1929, and that death occurred, on the date stated above, at 8:30 A m.

The CAUSE OF DEATH* was as follows:

Rheumatic Endocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Pulmonary Edema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) D. Mercer M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet

DATE OF BURIAL: 6/13 1929

20 UNDERTAKER: Mrs Cook

ADDRESS: 12 N Paca

OF DEATH in plain terms, so that it may be properly classified. Last statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Stout

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 46712

CERTIFICATE OF DEATH

E 46712

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Baltimore City Hosp. (Ward) 16

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna Stout

(a) RESIDENCE NO. 1934 Riggs ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem.

4 COLOR OR RACE: Whit

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Jan - 7 - 1848

7 AGE: Years 81 | Months 5 | Days 2 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Andrew Stout

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Hospital Record

(Address)

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/9/29

17 I HEREBY CERTIFY, That I attended deceased from 6/5, 1929, to 6/9, 1929

that I last saw h alive on 6/9, 1929

and that death occurred, on the date stated above, at 3 30 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Senile ulcers of both legs -

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary): Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. M. Pumphrey, M. D.

6/9, 1929 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: 6/12 1929

20 UNDERTAKER: William Cook — ADDRESS: 12/15 St Paul

JUN 11 1929 HAMILTON JONES, M. D.

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 46713

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 46713

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 404 Bluv ST. 17-25 WARD)

2-FULL NAME Mary Elizabeth Price

(a) RESIDENCE NO. 404 Bluv ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm Price

6 DATE OF BIRTH (month, day, and year): Aug 6th 1853

7 AGE: 45 Years 11 Months 4 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cook

(b) General nature of industry, business, or establishment in which employed (or employer): Cooking

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Wm Gilsham

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Mrs. Lottie (Address): 404 Druid Hill Ave

15 Filed JUN 11 1929

16 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 10 1929

17

I HEREBY CERTIFY, That I attended deceased from April 23, 1929, to June 10, 1929, that I last saw her alive on June 10, 1929, and that death occurred, on the date stated above, at 1 a.m.

The CAUSE OF DEATH* was as follows:

Organic Heart Disease

(duration) yrs. 1 mos 2 ds.

CONTRIBUTORY (Secondary) Bright's Disease

(duration) yrs. 1 mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) ..... M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery

DATE OF BURIAL: June 12, 1929

20 UNDERTAKER: Mrs. Kate R. Williams

ADDRESS 372 N. Schroeder St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46714

CERTIFICATE OF DEATH.

E 46714
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 322 n Caroline ST. (WARD) 19-2

2-FULL NAME Josephine Dawes.

(a) RESIDENCE NO. 322 n Caroline ST., WARD 19-2

(Usual place of abode)

Length of residence in city or town where death occurred 3 wks mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed or divorced HUSBAND of (or) WIFE of: James Dawes

6 DATE OF BIRTH (month, day, and year): May 9 1887

7 AGE: Years 42 | Months 1 | Days 1 | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Boarding House

(b) General nature of industry, business, or establishment in which employed (or employer): Keeper

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): N C

PARENTS

10 NAME OF FATHER: Bob Arrington

11 BIRTHPLACE OF FATHER (city or town) (State or country): N C

12 MAIDEN NAME OF MOTHER: May Powell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N C

14 Informant: Thomas Arrington

(Address) 322 N. Caroline St.

JUN 11 1929

Filed H. HANSON JONES, M. D.

By [signature] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 10 - 1929

17 I HEREBY CERTIFY, that I attended deceased from May 28, 1929 to June 10, 1929.

that I last saw her alive on June 9, 1929

and that death occurred, on the date stated above, at 7.15 A m.

The CAUSE OF DEATH* was as follows:

Phthisis Florida

(duration) yrs. 3? mos ds.

CONTRIBUTORY (Secondary) DBC

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Richmond Va

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Wm H Wright M. D.

(Address) 1209 Eastman

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery

DATE OF BURIAL: June May 12, 1929

UNDERTAKER: Mrs Katie P. Williams & Schroeder

ADDRESS 322

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 46715

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

40

E 46715

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph's Hospital 4-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lizzie Hicks.

(a) RESIDENCE NO. 1411 N Cairo 3d ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred ~~[illegible]~~ ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	Colored	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 24, 1910

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	19	2	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) Louisburg, (State or country) N.C.

PARENTS

10 NAME OF FATHER William Hicks

11 BIRTHPLACE OF FATHER (city or town) Oxford, (State or country) N.C.

12 MAIDEN NAME OF MOTHER Margaret Egerton

13 BIRTHPLACE OF MOTHER (city or town) Louisburg, (State or country) N.C.

14 Informant Margaret Hicks
(Address) 1411 Cairo St

15 Filed ..., 19... C. HAMPTON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/9/29.

17 I HEREBY CERTIFY, That I attended deceased from 5/17/, 1929, to 6/9/, 1929, that I last saw h~~er~~ alive on 6/9/, 1929, and that death occurred, on the date stated above, at 8-10 a. m.

The CAUSE OF DEATH* was as follows:

Chronic bilateral tuberculosis pulmonalis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute dilatation of heart

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes, Date of 5/31/29

Was there an autopsy? yes.

What test confirmed diagnosis? Symptoms & signs

(Signed) J. Mastin, M. D.

, 19 (Address) St. Joseph's Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cemetery	June 13, 1929

20 UNDERTAKER Mrs Katie R. Williams ADDRESS 3221 Schroeder St.

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46716 Kunle

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46716

CERTIFICATE OF DEATH

129

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2143 Kirk Avenue ST., 9-46 WARD)

2—FULL NAME Lillian B. Kunle

(a) RESIDENCE NO. 2143 Kirk Avenue ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Christian Kunle

6 DATE OF BIRTH (month, day, and year) Jan. 15. 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	46	4	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Henry Rausch

11 BIRTHPLACE OF FATHER (city or town) (State or country) German

12 MAIDEN NAME OF MOTHER Catherine Helen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Christian F Kunle

(Address) 2143 Kirk Ave.

15 Filed JUN 11 1929 19 H. MASON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 8, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 3d, 1929, to June 8th, 1929

that I last saw her alive on June 8th, 1929

and that death occurred, on the date stated above, at 11-30 a m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis (Bright's)

About- (duration) 1 yr. 6 mos. 6 ds.

CONTRIBUTORY (Secondary) Heart - Dropsical Effusion (duration) 6 yrs. 6 mos. 6 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual Clinical

(Signed) D. A. Waldron, M. D.

19 (Address) 210 East Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	6/11 1929
20 UNDERTAKER George J Ruth	ADDRESS 1730 Hanford Avenue

important. See instructions on back of certificates.

Spec.—2-29-25—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46717

100-001

CERTIFICATE OF DEATH

E 46717

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 921 E. Madison St. 10-15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Daniel Cooks

(a) RESIDENCE NO. 944 E. Madison ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Cooks

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant William Cooks

(Address) 921 E. Madison St.

15 Filed JUN 11 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9-1929

17

I HEREBY CERTIFY, That I attended deceased from May 30, 1929, to June 9, 1929

that I last saw h[illegible] alive on June 9, 1929

and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchopneumonia

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) A. G. Hamilton, M. D.

6/10, 1929 (Address) 733 Aisquith St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	June 12 1929

20 UNDERTAKER Chas. T. Johnson ADDRESS 418 N. Caroline St.

IMPORTANT—If death is due to any but natural causes, the property custodian, Police Department, must be notified. Fill out Notification of Accident, Form 2. If death occurred in a hospital, institution, or public building, the superintendent or person in charge must report it. See instructions on back of certificates.

Spec.—I-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46718

CERTIFICATE OF DEATH.

E 46718

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4802 Park Heights Ave ST. 27-56 WARD)

2-FULL NAME Hans Peter Jensen

(a) RESIDENCE No. 1103 Walnut Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Shelley

6 DATE OF BIRTH (month, day, and year) Jan.10,1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	4	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Denmark

PARENTS

10 NAME OF FATHER ----

11 BIRTHPLACE OF FATHER (city or town) (State or country) Denmark

12 MAIDEN NAME OF MOTHER ----

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Denmark

14 Informant Martin W. Jensen

(Address) 1103, Walnut Ave., Rognel Hts.

JUN 11 1929

C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9 1929

17 I HEREBY CERTIFY, That I attended deceased from Feby 4, 1929, to June 9, 1929, that I last saw him alive on June 9, 1929, and that death occurred, on the date stated above, at 7:30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Bright's Disease

Mitral Regurgitation (duration) 5 yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Endocarditis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. H. Duvall, M. D.

6/10, 1929 (Address) 1817 No. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL June 11, 29

20 UNDERTAKER John O. Mitchell & Sons,

ADDRESS 1900 Eutaw Pl

M. B. Mitchell

Spec.—2-29-28—L. F. S.—500 Bks.

Schroff

E 46719 HEALTH DEPARTMENT—CITY OF BALTIMORE 31 E 46719

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 816

CITY OF BALTIMORE: (No.) Baltimore City Hospitals (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rudolph Schroff

(a) RESIDENCE NO. 1618 Llewlyn ST.. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie Schroff

6 DATE OF BIRTH (month, day, and year) March 30/80

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	2	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Andrew Schroff

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Botching

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Minnie Schroff

(Address) 416 a. Mary Pl

15 Filed JUN 11 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/9/29

17 I HEREBY CERTIFY, That I attended deceased from 5/27/29, 19..., to 6/9, 19 29.

that I last saw him alive on 6/9, 19 29

and that death occurred, on the date stated above, at 4 30 a. m.

The CAUSE OF DEATH* was as follows:

Empyema of left chest

following pneumonia

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Cachexia + Toxemia

(duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of 5/28/29

Was there an autopsy? No

What test confirmed diagnosis? Operation + Clinical

(Signed) L. A. Pumphrey, M. D.

6/9, 1929 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oakwood Cem	June 12 1929
20 UNDERTAKER Philip Herwig	ADDRESS 2016 Aliceanna St

Important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46720

E 46720

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3731 Lee St., 25-75 Ward) Registered No. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catharine Anuszewski

(a) Residence No. 3731 Lee St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced. (Write the word) Widow

5a-If married, widowed, or divorced, HUSBAND of (or) WIFE of John Anuszewski

6-DATE OF BIRTH (month, day and year) Oct 28-1870

7-AGE. 58 yrs. 7 mos. 10 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Housewife

(b) General nature of Industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town). (State or Country), Poland

PARENTS.

10-NAME OF FATHER, Martin Josiuski

11-BIRTHPLACE OF FATHER (city or town). (State or Country), Poland

12-MAIDEN NAME OF MOTHER, Anna Surname not known

13-BIRTHPLACE OF MOTHER (city or town). (State or Country), Poland

11- (Informant) John Anuszewski

(Address) 515 S. Montford

Filed JN 11 1929 C. HAMILTON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 10-1929

17- I HEREBY CERTIFY, That I attended deceased from June 1 1929 to June 10 1929 that I last saw h.r alive on June 10 1929 and that death occurred, on the date stated above, at 7 15 A. m. The CAUSE OF DEATH* was as follows:

Apoplexy

Arteriosclerosis

Myocarditis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chron Myocarditis

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Leon I. Horlick M. D.

June 10, 1929 (Address) 4700 Pennington Av

*State the **Disease Causing Death**, or in deaths from **Violent Causes** state (1) **Means and Nature of Injury**, and (2) whether **Accidental Suicidal, or Homicidal.** (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. St. Stanislaus DATE OF BURIAL. June 13 1929

UNDERTAKER. F. W. Ozog ADDRESS 1730 Eastern Av

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46721

CERTIFICATE OF DEATH

92 E 46721

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE (No. 3526 W. Garrison Blvd (WARD) 58

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Max Silberman

(a) RESIDENCE NO. 3526 W. Garrison Blvd ST.

(Usual place of abode) WARD

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Rachael Silberman

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Wendel Silberman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Rachael Silberman

(Address) 3526 W. Garrison Blvd

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11-29

17 I HEREBY CERTIFY, That I attended deceased from May-20th 19 29, to June-11- 19 29, that I last saw him alive on June-10- 19 29 and that death occurred, on the date stated above, at 12 15 a. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Coronary Thrombosis

(duration) yrs. mos. ds. a few hours

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) Herman Siedel, M. D.

Jun 11 19 29 (Address) 2404 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Lebanon Cem

DATE OF BURIAL 6/10 19 29

20 UNDERTAKER Jack Laws

ADDRESS 1409 Ensalt Ave

important. See instructions on back of certificates.

C. HAMPSON JONES

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46722

90 E 46722

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1015 E Pratt St. 3-5 Ward)

2-FULL NAME Joseph H. Levenson

(a) RESIDENCE NO. 1015 E Pratt St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? 7 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Tobie Levenson

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	75	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Russia

PARENTS

10 NAME OF FATHER Moses Levenson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Antonen

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Adolph Levenson
(Address) 1015 E Pratt St

15 Filed ..., 19... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic
Arteriosclerosis

(duration) 1 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Old age

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? 1015 E Pratt

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James H. Parlett, M. D.

19 29 (Address) 7009 Eldon

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Hill Park

DATE OF BURIAL 6-11-1929

20 UNDERTAKER Jack Bruns

ADDRESS 1439 E Balto St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46723

CERTIFICATE OF DEATH

57 E 46723

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2521 Aisquith ave ST. 7-7-56 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Freida Karloff

(a) RESIDENCE NO. 2521 Aisquith ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Harry Karloff

6 DATE OF BIRTH (month, day and year): [illegible]

7 AGE: Years 68 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Abraham

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Stefana Kamod

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: J. Lewis
(Address) 1439 E Balto St.

15 Filed ..... 19 ..... HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/11/29

17 I HEREBY CERTIFY, That I attended deceased from 10/20, 1928, to 6/11, 1929, that I last saw h[illegible] alive on 6/10 1929 and that death occurred, on the date stated above, at 4:30 a.m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia
(Terminal)

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Diabetes

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

6/11, 19[illegible] (Address) 23[illegible] Eutaw [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Levine Cordals	6-11-1929
20 UNDERTAKER	ADDRESS
Jack Levine, 1439	E Balto St

Spec.—1-10-21—M&T—1500 Blks.

E 46724 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

65-006
E 46724

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No.) 9-16 ST. (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Margaret Parsons.

(a) RESIDENCE NO. 1007 E Hoffman ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Framer C. Parsons

6 DATE OF BIRTH (month, day, and year): Sept. 28. 1901

7 AGE: Years 27 Months 8 Days 13

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Albert F. Knauff.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: Jennie I. Eckard

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant: Mrs Jennie Adelphi Mother (Address): 1007 E. Hoffman St.

15 Filed JUN 11 1929 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 10 1929

17 I HEREBY CERTIFY, That I attended deceased from May 14, 1929, to June 10, 1929, that I last saw her alive on June 9, 1929, and that death occurred, on the date stated above, at 2:15 A m.

The CAUSE OF DEATH* was as follows:

Lymphatic Leukaemia

(duration) ? yrs mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Blood Examination.

(Signed) Frederick D Wolf M. D.

6/10 1929 (Address) Sinai Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery DATE OF BURIAL: June 13, 1929

20 UNDERTAKER: Elmer W. Conklin ADDRESS: 924 E. Eager

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should fill CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46725

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46725

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO. 17-25-90

CITY OF BALTIMORE: (No. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Dan Nelson

(a) RESIDENCE NO. 653 Bradley ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wash. Nelson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Charlotte ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Records of

(Address) Baltimore City Hospitals

15 Filed JUN 11 1929, C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 15, 1928, to June 10, 1929, that I last saw him alive on June 10, 1929, and that death occurred, on the date stated above, at 5:00 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic, Myocardial Insufficiency

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis & Hypertension (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) M. M. McLean, M. D.

, 19 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Calvary	June 13 1929
20 UNDERTAKER	ADDRESS
Mrs. R. A. Elliott	1725 Ashland Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46726

CERTIFICATE OF DEATH

90

E 46726

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3008 Mayfield Ave WARD 26-40 ST.)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frances Regina Barrett

(a) RESIDENCE NO. 3008 Mayfield Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced (or) WIFE of Wm J Barrett

6 DATE OF BIRTH (month, day, and year) April 20-1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Peter Wisbard

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Sauer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14

Informant Geo L Barrett

(Address) 3008 Mayfield

15 Filed JUN 11 1929 C. HAMPSON JONES, M. D. Registrar

Per KCC

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9-1929

17

I HEREBY CERTIFY, That I attended deceased from June 3, 1929, to June 9, 1929, that I last saw h alive on June 6, 1929, and that death occurred, on the date stated above, at 9 05 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Progressive Cardiac Asthenia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward L Covel, M. D.

6/10 1929 (Address) 413 W Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	June 12 1929
20 UNDERTAKER	ADDRESS
Stephen J. Fialkowski Inc.	1000 N. Kenwood Ave

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46727

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46727.

CERTIFICATE OF DEATH

1—PLACE OF DEATH

BALTIMORE CITY HOSPITALS

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST. 4 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William S. Harrington

(a) RESIDENCE NO. 122 East Pratt ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 10 mos. 8 ds. How long in U. S., if foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella B. Harrington

6 DATE OF BIRTH (month, day, and year) Aug 1 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	66	10	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER Wm S. Harrington

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER M. Louisa Moffitt

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Pennsylvania

14 Informant .....
(Address) BALTIMORE CITY HOSPITALS

15 Filed JUN 11 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-9-29

17 I HEREBY CERTIFY, That I attended deceased from 1-16-29 to 6-9-29,

that I last saw him alive on 6-9-29,

and that death occurred, on the date stated above, at 12-30 p.m.

The CAUSE OF DEATH* was as follows:

Hemorrhage into Encephalon

Hypertension

Arteriosclerosis

(duration) over yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage into Encephalon

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Typical case.

(Signed) Marvin M. McLean M. D.

6-9, 1929 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	June 11 1929
20 UNDERTAKER John H. Denny	ADDRESS 715 Light St

important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46728

CERTIFICATE OF DEATH.

E 46728

REGISTERED NO. 1616

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hosp ST. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Thomas

(a) RESIDENCE NO. Provident Hosp ST. " WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years | Months | Days | If LESS than 1 day, 12 hrs. or min.

12 hrs

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Vernal Gross

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: Mary Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Anne Arundel Co. Md

14 Informant: Mother

(Address)

Filed JUN 11 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6 - 7 - 1929

17 I HEREBY CERTIFY, That I attended deceased from , 19 , to , 19 ,

that I last saw her alive on 6 - 7 - 1929

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Ordinary

(Signed) Wm H. Frazier M. D.

, 19 (Address) Provident Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Commissioner Health

JUN 10 1929

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

UNIVERSITY OF MARYLAND

Spec—12-23-21—E.B.R.S.—400 Bks.

E 46729

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001

E 46729

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 522 W. Lee St., 22-30 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Baby Girl Cook-Bay

(a) Residence No. 522 W. Lee St. St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Black

5-Single, ~~Married~~, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 7, 1929

7-AGE. ....yrs. ....mos. ....ds. If LESS than 1 day, 17 hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER, Gilbert Cook-Bay

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Luzerne Mississippi

12-MAIDEN NAME OF MOTHER, Marie Fulgham-Bay

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Tuskaloosa Alabama

14- (Informant)

(Address)

15- (Filed) (Registered) HAMPSON JONES, M. D. Registrar.

JUN 11 1929

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). June 8, 1929

17- I HEREBY CERTIFY, That I attended deceased from June 7, 1929 to June 8, 1929 that I last saw he alive on June 7, 1929 and that death occurred, on the date stated above, at 3:30 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth (6 months + 3 weeks old)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Louis H. Haag M. D.

6/10, 1929 (Address) Univ. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. UNIVERSITY OF MARYLAND

DATE OF BURIAL, ..., 19....

20-UNDERTAKER. Commissioner Health.

ADDRESS 10

JUN 10 1929

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 46730

CERTIFICATE OF DEATH

E 46730

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Baltimore City Hosp. 25-B WARD)

2—FULL NAME Henry Butler

(a) RESIDENCE NO. 108 Ampere Pl. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Record

(Address)

15 Filed JUN 11 1929 C. HAMPSON JONES, M. D. Registrar

Pct.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/9/29

17

I HEREBY CERTIFY, That I attended deceased from 1/1, 1925, to 6/9, 1929,

that I last saw him alive on 6/8, 1929

and that death occurred, on the date stated above, at 12:30 a. m.

The CAUSE OF DEATH* was as follows:

Myocarditis Arteriosclerosis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) L. M. Lumpkin, M. D.

6/9, 1929 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	June 12 1929
20 UNDERTAKER	ADDRESS
N. E. Brown & Son	1538 N. Mtn.

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46731

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44 V

E 46731

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 539 N. Longwood ST.) 70-70 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Frances Ackerman

(a) RESIDENCE NO. 539 N. Longwood ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Louis Ackerman

6 DATE OF BIRTH (month, day and year) June, 6th. 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65		3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At home

(c) Name of employer

9 BIRTHPLACE (city or town) Providence
(State or country) Maryland

PARENTS

10 NAME OF FATHER Joshua Corbin

11 BIRTHPLACE OF FATHER (city or town) Providence
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary E. Evans

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Lenore Ackerman
(Address) 539 N. Longwood St.

Filed JUN 11 1929, 19 — C. C. JAMESON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June, 9th. 1929

17 I HEREBY CERTIFY, That I attended deceased from May 1st, 1929 to June 8, 1929, that I last saw her alive on June 8, 1929, and that death occurred, on the date stated above, at 6.30 A.m.

The CAUSE OF DEATH* was as follows:

Hepatic Carcinoma
Metastasis.

CONTRIBUTORY (Secondary) Cardiac Asthenia (duration) yrs. 6 mos. ds.

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? 14 yrs ago operated on for Carcinoma of Breast

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Albert L. Levy, M. D.

6/10, 29 (Address) 800 E. Preston St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery — DATE OF BURIAL June, 12" 19 29

20 UNDERTAKER Dep't Cook — ADDRESS 1003 West Baltimore St.

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46732

CERTIFICATE OF DEATH

100-001

E 46732

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Baltimore City Hosp. WARD) 11-25

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Eureka Young

(a) RESIDENCE NO. 435 W. Monument ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. [illegible] mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unk

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Isaac Hill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie Addison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed JUN 11 1929, 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/6/29

17

I HEREBY CERTIFY, That I attended deceased from 5/29, 1929, to 6/6, 1929, that I last saw h[illegible] alive on 6/6, 1929 and that death occurred, on the date stated above, at 8 [illegible] a.m.

The CAUSE OF DEATH* was as follows:

Cellulitis of right thigh

(duration) Unknown,

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? C. C. Complete

(Signed) Baltimore City Hosp. M. D.

6/6, 1929 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart	6.11 1929
20 UNDERTAKER J. J. Leahey & Son	ADDRESS 1318 Light St

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46733

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 46733

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Baltimore City Hosp. St. 2-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ernest Walker

(a) RESIDENCE NO. 105 W. Conway ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of): Mrs. Mary D. Walker

6 DATE OF BIRTH (month, day, and year): 1884 - Sept 5

7 AGE: Years 44 | Months 9 | Days 4 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED:
(a) Trade, profession or particular kind of work: Fireman
(b) General nature of industry, business, or establishment in which employed (or employer): Unknown
(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Ill.

PARENTS

10 NAME OF FATHER: Wm Walker

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ill.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Hospital Records
(Address)

15 Filed JUN 11 1929, 19 — C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/9/29

17 I HEREBY CERTIFY, That I attended deceased from May 11, to June 9, 19 29, that I last saw h[illegible] alive on June 9, 19 29, and that death occurred, on the date stated above, at 11.20 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum Gen T.B. exp

(Signed) Henry Schmidt M. D.

19 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross

DATE OF BURIAL: 6-12 1929

20 UNDERTAKER: Bernard C. Hank

ADDRESS: 1000 S. Paca St

important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

46734

E 46734 REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) Mercy Hospital St. 4-7 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Grace Emmart

(a) RESIDENCE NO. 48 N. Prospect Ave St. Catonsville Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm. T. Emmart

6 DATE OF BIRTH (month, day, and year): July 21 1901

7 AGE: 27 Years 10 Months 20 Days 28

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country): Maryland

PARENTS

10 NAME OF FATHER: Eby. Myrtel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Clara Boyd

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Wm T Emmart

(Address): 48 N Prospect Ave

15 Filed JUN 11 1929 19

Registrar J. HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/11/29 19

17 I HEREBY CERTIFY, That I attended deceased from 6/10/29, 19, to 6/11/29, 19,

that I last saw h[illegible] alive on 6/11/29, 19,

and that death occurred, on the date stated above, at 3 10 AM m.

The CAUSE OF DEATH* was as follows:

Cerebral Tumor

(duration) yrs. 2½ mos. da.

CONTRIBUTORY (Secondary): Respiratory Failure

(duration) yrs. mos. da.

18 Where was disease contracted

if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) J. S. Winstead, M. D.

. 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — Date of Burial: 6-14 19 29

20 UNDERTAKER: J Bernard Hake — ADDRESS: 1000 Race St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

~~22469~~ ~~E 46735~~

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46735

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 26-1 WARD) 161-0

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Donald Gorge

(a) RESIDENCE NO. 1111 E. Boulton ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 4/23/29

7 AGE	Years	Months 1	Days 11 / 48	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work..... 0 0

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Margt Reddemont

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUN 11 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 19 29

17 I HEREBY CERTIFY, That I attended deceased from April 24, 1929, to June 10, 1929, that I last saw h[illegible] alive on June 10, 1929, and that death occurred, on the date stated above, at 7.50 P m.

The CAUSE OF DEATH* was as follows:

Exenteritis

(duration) yrs. mos 41 ds.

CONTRIBUTORY (Secondary) Bilateral Otitis media

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H. C. Goodwin, M. D.

6/1, 1929 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem. DATE OF BURIAL 6/1 1929

20 UNDERTAKER George W Zirkler ADDRESS 1737 Eager 18

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46736

CERTIFICATE OF DEATH

129 E 46736

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1321 W Baltimore St. 3-5 WARD)

2—FULL NAME Margaret J McCormick

(a) RESIDENCE NO. 1321 W Baltimore WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: John McCormick

6 DATE OF BIRTH (month, day, and year): Aug 7 1850

7 AGE — Years: 78 | Months: 10 | Days: 2 | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Michael Donohue

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: John J McCormick

(Address): 1321 W Baltimore St

15 Filed 11 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 9, 1929.

17 I HEREBY CERTIFY, that I attended deceased from May 16, 1929 to June 9th, 1929

that I last saw her alive on June 9th, 1929

and that death occurred, on the date stated above, at 11 30 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Arterio Sclerosis

with Hemiplegia

Chr. Nephritis, cholangitis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Hypostatic Congestion of Lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Findings

(Signed) James Hitchcock M. D.

, 19 (Address) 715 Frederick Ave, Catons.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Catholic Cem DATE OF BURIAL: 6/12/29

UNDERTAKER: Geo A Talley ADDRESS: Fulton Fayette

important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 46737

HEALTH DEPARTMENT—CITY OF BALTIMORE

111-001

E 46787

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of BALTIMORE: (No. Mercy Hospital St., 15-67 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wilson, J. Calvin J. Calvin Wilson

(a) RESIDENCE NO. 3048 West North Ave St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 2, 1882

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
	47	—	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dept. Manager. Gb

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer McCormick Spice Co.

9 BIRTHPLACE (city or town) Shepherdstown, Md

(State or country)

PARENTS

10 NAME OF FATHER J Calvin Wilson

11 BIRTHPLACE OF FATHER (City or town) Md

(State or country)

12 MAIDEN NAME OF MOTHER May V Crozier

13 BIRTHPLACE OF MOTHER (city or town) Md

(State or country)

14 Informant Elizabeth C. Wilson

(Address) 3048 W. North Ave

15 Filed NOV 1 1929 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/11 1929

17 I HEREBY CERTIFY, That I attended deceased from 6/2, 1929, to 6-11, 1929, that I last saw h alive on 6-11-29, 1929, and that death occurred, on the date stated above, at 12 30 a m.

The CAUSE OF DEATH* was as follows:

Peptic ulcer

(duration) intermittent yrs. mos. ds.

CONTRIBUTORY (Secondary) Gastric Haemorrhage

(duration) yrs. mos 12 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Nelson Carey, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem Date of Burial 6/13/29

20 UNDERTAKER Geo W Fahey ADDRESS Fulton & Fayette

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46738

CERTIFICATE OF DEATH

90 E 46738

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1505 Clarkson St. ST 23-31 WARD)

2—FULL NAME Ellen C. Kyne

(a) RESIDENCE NO. 1505 Clarkson ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Michael J. Kyne

6 DATE OF BIRTH (month, day, and year) April 11 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	57	2	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Virginia
(State or country)

PARENTS

10 NAME OF FATHER James Cassidy

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Rose Fox

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Miss Rose Cassidy

(Address) 123 E. Fort Ave

15 Filed N 11 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-11-1929

17 I HEREBY CERTIFY, That I attended deceased from March 2, 1929, to 6/11, 1929, that I last saw h alive on 6/11, 1929 and that death occurred, on the date stated above, at 6 15 A.M.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 3 mos. da.

CONTRIBUTORY (Secondary) Acute Arteriolar Sclerosis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. Mihelich, M. D.

6/11, 1929 (Address) 1279 William

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem.

DATE OF BURIAL 6/14 1929

20 UNDERTAKER L. Few McCully

ADDRESS 120 E Fort

important. See instructions on back of certificates.

Spec.—2-20-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46739

CERTIFICATE OF DEATH

164 ✓ E 46739

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 157 Augusta Ave ST. 20-7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Catherine C. Comegys

(a) RESIDENCE NO. 157 Augusta Ave ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~, (write the word)
Female	White	Single

5a If ~~married~~, ~~widowed~~, or ~~divorced~~ HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	about 97			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Co. Md

PARENTS

10 NAME OF FATHER Bastus Comegys

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Eastern Shore Md

12 MAIDEN NAME OF MOTHER Evelina Dorsey

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore Md

14 Informant Nellie Seleman

(Address) 157 Augusta Ave

Filed JUN 12 1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1929, to June 11, 1929, that I last saw h~~er~~ alive on June 11, 1929 and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E R Demuy, M. D.

6/11, 1929 (Address) 1732 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cem	June 14 1929
20 UNDERTAKER	ADDRESS
Henry Menkens & Sons Co	Oldtown Md. C.H.B.S.

IMPORTANT. See instructions on back of certificates.

M. Scholastica Moran

Spec. -7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46740 90

CERTIFICATE OF DEATH

E 46740

1-PLACE OF DEATH Mt. St. Agnes College, Mt. Washington REGISTERED NO. 27-54

City of BALTIMORE: (No. ____ St. ____ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sister M. Scholastica Moran

(a) RESIDENCE NO. Mt St. Agnes College St. Mt-Washington Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S. if of foreign birth? 75 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 1st 1844

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min..
	84		8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Religious

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Dublin (State or country) Ireland

PARENTS

10 NAME OF FATHER John Moran

11 BIRTHPLACE OF FATHER (City or town) Dublin (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary —?

13 BIRTHPLACE OF MOTHER (city or town) Dublin (State or country) Ireland

14 Informant Sister Mary Josephus (Address) Mt St. Agnes College.

15 Filed JUN 12 1929 C. HAMPSON JONES, M. D., Registrar

Paid [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9, 1929

17 I HEREBY CERTIFY, That I attended deceased from January, 1926, to June 8, 1929, that I last saw her alive on June 8, 1929, and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerotic Cardio Vascular Disease

Chronic Myocarditis

Auricular Fibrillation

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) J. Raymond Peters, M. D.

June 11 1929 (Address) 1908 W Lexington St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Agnes Convent Cem — Date of Burial June 11 1929

20 UNDERTAKER Henry Jenkins & Sons Co — ADDRESS Cor of Mt-College

N 12 1929

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Chesley Bean

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46741

CERTIFICATE OF DEATH

3 V

E 46741

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST., 16-23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Chesley Bean

(a) RESIDENCE NO. 1339 Mosher st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Porter

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bermuda

PARENTS

10 NAME OF FATHER Ormand Bean

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bermuda

12 MAIDEN NAME OF MOTHER Susan Grant

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bermuda

14 Informant Hospital Records

(Address)

15 Filed 6-9, 1929 C. HAMPSON JONES, M. D. Registrar

CN 121929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9, 1929

17

I HEREBY CERTIFY, That I attended deceased from March 18, 1929, to June 9, 1929,

that I last saw him alive on June 9, 1929,

and that death occurred, on the date stated above, at 2.45 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical and autopsy

(Signed) Henry C. Smith, M. D.

6-9, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Auburn — DATE OF BURIAL June 13 1929

20 UNDERTAKER Sam'l N. Chase & Son — ADDRESS 1100 N. Mosher

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

Madonna

46742

HEALTH DEPARTMENT—CITY OF BALTIMORE

188-001

CERTIFICATE OF DEATH

E 46742

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Penna R.R. nr Broadway St. 8-17 Ward)

2-FULL NAME Carlo Madono (Madonna)

(a) RESIDENCE NO. 1010 E. Hoffman St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Catherine Madono

6 DATE OF BIRTH (month, day, and year) Mch 1895

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	34	3		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Penna R.R.
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Italy

PARENTS

10 NAME OF FATHER Frank Madono

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Italy

12 MAIDEN NAME OF MOTHER L. Ciampini

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Italy

14 Informant Nick Pace
(Address) 1504 E. Hoffman St

15 Filed JUN 12 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Run over by Penna R.R. Engine
(Rashed head and other injuries)
Accidental.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) C. Hampson Jones, M. D.

6/12/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	6/13 1929
20 UNDERTAKER George J. Rueth	ADDRESS 1735 Harford Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JUN 12 1929

Spec.—1-10-21—M&T—1500 Blks.

E 46743

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46743

CERTIFICATE OF DEATH.

161-001

1-PLACE OF DEATH

Johns Hopkins Hospital

CITY OF BALTIMORE: (NO.) 5-8 ST., (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Magenta

(a) RESIDENCE No. 908 E. Eager ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, ~~Married~~, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 27th 1929

7 AGE Years Months Days 14 If LESS than 1 day, hrs. or min. 6

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) U. S.

PARENTS

10 NAME OF FATHER Charles Magenta

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Carmela Carlon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant (Address) Mrs. Rose Magenta 908 E. Eager St.

Dec 12 1929 19

C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11 1929

17 I HEREBY CERTIFY, That I attended deceased from May 27, 1929 to June 11, 1929 that I last saw her alive on June 11, 1929 and that death occurred, on the date stated above, at 6.55 P. m.

The CAUSE OF DEATH* was as follows:

PREMATURITY

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

What was there an autopsy?

What test confirmed diagnosis?

(Signed) Alan Hustrain M. D.

19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: 6/12 1929

20 UNDERTAKER: Geo & Ruth — ADDRESS: 1135 Hartford Ave

121929

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 46744

HEALTH DEPARTMENT—CITY OF BALTIMORE

31 E 46744

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of Baltimore: (No. 230 N. Gilmore St. 19-27 Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Neal McCrary

(a) RESIDENCE NO. 230 - N. Gilmore St., Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) unk

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	47	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Lab
(b) General nature of industry, business, or establishment in which employed (or employer) Odd
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Ga

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Unknown

14 Informant Edna Lieutenant
(Address) 230 N. Gilmore St

15 Filed JUN 7 1929 16 C. HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Jun 10 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to L death on the day stated above.
The CAUSE OF DEATH* was as follows:

Pulmonary Hemorrhage

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted
If not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Chas. H. Browne M. D.

Jun 10, 1929 (Address) 3601 3rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Md. S. National Cem	June 13th 1929
20 UNDERTAKER A. Jones	ADDRESS 111 S. Gilmore

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

E 46745 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 46745

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 637 Harvey ST. 24-33 WARD.

2-FULL NAME Audrey Hubbard

(a) RESIDENCE NO. 637 Harvey ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 9. 1929

7 AGE: Years ..... Months ..... Days 3 ..... If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto, Md.

PARENTS

10 NAME OF FATHER: Wm. J. Hubbard

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Clara O'Ble

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto, Md.

14 Informant: Mrs. Shea
(Address): 637 Harvey St.

15 WILLIAM SIMPSON JONES, M. D.
6/12 1929 .19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/11 1929

17 I HEREBY CERTIFY, That I attended deceased from June 9, 1929, to June 11, 1929, that I last saw h[illegible] alive on June 11, 1929, and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Hemorrhage around umbilicus

(duration) ..... yrs. ..... mos. 2 hrs.

CONTRIBUTORY (Secondary) Hemorrhage Umbilicus

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

6/12 1929 (Address) 16 Randall

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem.

DATE OF BURIAL: June 12, 29

20 UNDERTAKER: Margaret D. Flynn

ADDRESS: 422 Light St

121929

nation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46746

CERTIFICATE OF DEATH.

89 E 46746

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1408 Park Ave ST., 14-20 WARD)

2-FULL NAME William Berrien Rogers

(a) RESIDENCE NO. 1408 Park Ave ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Susan Rogers

6 DATE OF BIRTH (month, day, and year) March 4 1863

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	66	3	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) ..... (State or country) Md

PARENTS

10 NAME OF FATHER Chas. Rogers

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Richardson

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Md

14 Informant John B. Rogers (Address) 315 Thorndale Rd

15 Filed JUN 12 1929 C. HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12 1929

17 I HEREBY CERTIFY, That I attended deceased from June 11th, 1929, to June 12th, 1929, that I last saw him alive on June 11th, 1929, and that death occurred, on the date stated above, at 1, 9, m.

The CAUSE OF DEATH* was as follows:

Angina

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Gen. arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) J. D. Lightner, M. D.

6/12, 1929 (Address) 211 W. Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem. DATE OF BURIAL June 14 1929

20 UNDERTAKER Chas. E. Branch ADDRESS 802 Madison Ave

MEDICAL CERTIFICATE OF DEATH should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 46747

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46747

159-002

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

Registered No.....

City of BALTIMORE: (No. 2124 E Chase St. 8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME..... Baby Smith

(a) Residence No. 2124 E. Chase St., 8 Ward.....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ___ yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Female

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the Word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of ___

6-DATE OF BIRTH (month, day and year) June 11 1929

7-AGE, ___ yrs. ___ mos. ___ ds.

If LESS than 1 day, 1 hrs. or ___ min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work..... None

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) (State or Country), Balto Md

PARENTS.

10-NAME OF FATHER, Frank J Smith

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Balto Md

12-MAIDEN NAME OF MOTHER, Elsie E Schreck

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md

14-

(Informant)... Elsie E Schreck

(Address)... 2124 E. Chase St.

15-

Filed ..... 192 C. HAMPSON JONES, M. D. Registrar.

Par

JUN 12 1929

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 11 1929

17- I HEREBY CERTIFY, That I attended deceased from June 11, 1929 to June 11, 1929

that I last saw h.. alive on June 11, 1929

and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

(Inanition)

Congenital Malformation

4 hrs Duration

(Duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY ___
(Secondary)

(Duration) ... yrs. ... mos. ... ds.

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of.....

Was there an autopsy? No

What test confirmed diagnosis? ___

(Signed) B. O. Herzog M.D.

6/12, 1929 (Address) 1305 N. Patterson Pk Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, Mt Carmel Cem. DATE OF BURIAL, June 12, 1929

20-UNDERTAKER, George W. Zirkler ADDRESS 137 E. Eager St.

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-23—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46748 — 1—PLACE OF DEATH

90

E 46748 — REGISTERED NO.

CITY OF BALTIMORE: (No. 631 S. Montford Ave. (ST.) 12 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Radcliffe Nawy.

(a) RESIDENCE NO. 631 S. Montford Ave. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Grace E. Nawy

6 DATE OF BIRTH (month, day, and year) March 14/1866

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	63	2	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mariner 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dorchester Co. Md.

PARENTS

10 NAME OF FATHER Thomas Nawy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Taylor Island

12 MAIDEN NAME OF MOTHER Cornelia Radcliffe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dorchester Co. Md.

14 Informant Mrs. Grace E. Nawy

(Address) 631 S. Montford Ave

Filed ... 19 ... Registrar

CN 121929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11 1929

17 I HEREBY CERTIFY, That I attended deceased from Apr. 20, 1929, to June 11, 1929, that I last saw him alive on June 10, 1929 and that death occurred, on the date stated above, at 3 a. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Arteriosclerosis

(duration) 9 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Geo. D. Libby, M. D.

19 (Address) 423 S. Patterson Pk. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount	6/13/29
20 UNDERTAKER	ADDRESS
Charles H. Keehner	1532 Hollins

HAMPSON JONES, M. D.

Registrar

OF DEATH in plain terms, so that it may be properly classified. Each statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46749

CERTIFICATE OF DEATH

166 ✓

E 46749
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Balt City Hospital St. 36-37 Ward)

2-FULL NAME Stephen Zavetz

(a) RESIDENCE NO. 507 New Kirk St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Mal	White	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Elizabeth Zavets

6 DATE OF BIRTH (month, day, and year) Dec 25 1883

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	45	5	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Grocer
(b) General nature of industry, business, or establishment in which employed (or employer) Retail
(c) Name of employer Self

9 BIRTHPLACE (city or town) .....
(State or country) Hungary

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Hungary

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Hungary

14 Informant Mrs Elizabeth Zavetz
(Address) 507 S. New Kirk St

Filed JUN 12 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10 192 9

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows

Acute Nephritis, from taking Iodine Hg, and Suicidal Wrist Incision

(duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? 507 New Kirk St

Did an operation precede death? No Date of .....

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) James M Carlson, M. D.

June 10 1929 (Address) 702 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart Cem — DATE OF BURIAL June 12 1929

20 UNDERTAKER John Ellis — ADDRESS 208 Orleans

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 43750 — 74-001 — E 46750

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals — REGISTERED NO.

CITY OF BALTIMORE: (No. ____ ST 24-33 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Gertrude H. Davis

(a) RESIDENCE NO. 1145 Riverside Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Davis

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	30			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Stepfather- Peter Myers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary Shook

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records of

(Address) Baltimore City Hospitals

15 Filed JUN 12 1929, 19 — C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 9, 1929, to June 11, 1929, that I last saw h-er alive on June 11, 1929 and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage, Nt

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Malignant Hypertension (18 Yrs long)

(duration) yrs. 18 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) Marvin M. McClean, M. D.

, 19 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olive Balto Co	June 13 1929
20 UNDERTAKER	ADDRESS
L. Lenowitch Son	2415 Eastern Ave

IMPORTANT. See instructions on back of certificates. Write in plain terms, so that it may be properly classified. Last statement of occupation.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46751

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

E 46751

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 17-24 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Solomon Cornish

(a) RESIDENCE NO. 1208 Shields Alley ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nora Cornish

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waiter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Simon Cornish

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Lucy ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Records of

(Address) Baltimore City Hospitals

Filed JUN 12 1929 HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1929, to June 11, 1929, that I last saw him alive on June 11, 1929 and that death occurred, on the date stated above, at 10:30 A. M.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic
Myocardial Insufficiency

(duration) yrs. ✓ mos. ds.

CONTRIBUTORY (Secondary) Old Cerebral Hemorrhage, ?, with Left Hemiplegia (duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Marvin W. Wilson, M. D.

, 19 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cem. DATE OF BURIAL 6-13-1929

20 UNDERTAKER David Carter ADDRESS 916 Eutaw

important. See instructions on back of certificates.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

46752

CERTIFICATE OF DEATH

80 E 46752

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 708 Pine Al 4-7 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Viola Gails

(a) RESIDENCE NO. 708 Pine Al. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 7 mos. 2 ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 Color or Race: Col'd

5 Single, Married, Widowed, or Divorced. (write the word): S.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct 22-1928

7 AGE: Years 7 Months Days 20 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) Balto Md

(State or country)

PARENTS

10 NAME OF FATHER Otti Gails

11 BIRTHPLACE OF FATHER (City or town)

(State or country) N C.

12 MAIDEN NAME OF MOTHER Hanie Owens.

13 BIRTHPLACE OF MOTHER (City or town)

(State or country) Baltimore,

14 Informant Family Dr

(Address) 708 Pine al.

Filed JUN 12 1929

C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11 1929

17 I HEREBY CERTIFY, That I attended deceased from June 9, 1929, to June 11, 1929, that I last saw h alive on June 11, 1929, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

E Clampsia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. H. Norwood, M. D.

June, 19 (Address) 939 or Fayette E.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Auburn Cem

Date of Burial: 6-13 1929

UNDERTAKER: Stanard Carter, Co Inc

ADDRESS 916

Spec.—2-29-28—L. F. S.—500 Bks.

E 46753

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

38 E 46753

REGISTERED NO.

1—PLACE OF DEATH Balto City Hospts

CITY OF BALTIMORE: (No. Balto Md ST. 10-15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Algernon Carter

(a) RESIDENCE NO. City Jail ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work do

(b) General nature of industry, business, or establishment in which employed (or employer) Laborer

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Balto City Hospt

(Address) Balto Md

15 Filed ..... 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-10-29

17 I HEREBY CERTIFY, That I attended deceased from 6-5, 19 29 to 6-10, 19 29

that I last saw him alive on 6-9-, 19 29

and that death occurred, on the date stated above, at 1 A m.

The CAUSE OF DEATH* was as follows:

Terminal Bronchopneumonia
Cardiac Failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Psychosis - Cerebrospinal Lues.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) John Fedsmith, M. D.

6/10, 1929 (Address) Balto City Hospts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

UNIVERSITY OF MARYLAND
JUN 12 1929
B. Commissioner of Health

JUN 12 1929

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46754

CERTIFICATE OF DEATH

9°

E 46754

REGISTERED NO.

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE: (No. 26-27 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Henry Wilmer

(a) RESIDENCE NO. 6 ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 89 yrs. mos. ds. How long in U. S., if foreign birth? — yrs. mos. ds.

BALTIMORE CITY HOSPITALS

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	?

5a If married, widowed, or divorced BUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	89			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer (formerly)

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) ?

14 Informant Records (Address)

15 Filed JUN 12 1929 (19) C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-8-29

17

I HEREBY CERTIFY, That I attended deceased from 9-21, 19 21, to 6-8, 19 29, that I last saw him alive on 6-8, 19 29 and that death occurred, on the date stated above, at 2-30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis; Cerebral Senile Dementia (duration) 8 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Gram.

(Signed) Marion M. McLean, M. D.

6-8, 19 29 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
UNIVERSITY OF MARYLAND	19
20 UNDERTAKER B.	ADDRESS JUN 12 1929

Commissioner Health

important. See instructions on back of certificates.

JUN 12 1929

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46755 — CERTIFICATE OF DEATH — 164 — E 46755

1—PLACE OF DEATH Baltimore City Hospitals — REGISTERED NO. .....

CITY OF BALTIMORE: (No. ..... ST., 4-6 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Richard Mallory

(a) RESIDENCE NO. ? Market Place ST., ... WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): England

PARENTS

10 NAME OF FATHER: Thomas ?

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Betty Daly

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Records of

(Address): Baltimore City Hospitals

JUN 12 1929

Date ..... 1929 — THOMPSON JONES, M. D. — Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 10, 1929

17 I HEREBY CERTIFY, That I attended deceased from January 3, 1929, to June 10, 1929.

that I last saw him alive on June 10, 1929

and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Senility

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no What test confirmed diagnosis? Physical exam

(Signed) Marian L. McClain, M. D.

. 19 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
UNIVERSITY OF MARYLAND	JUN 12 1929

20 UNDERTAKER: Commissioner Health. ADDRESS

Be important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 46756

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

45 ✓

E 46756

1—PLACE OF DEATH

REGISTERED NO. 9-46

CITY OF BALTIMORE: (No. 2100 Harford Ave ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Maggie B Kamm

(a) RESIDENCE NO. 2100 Harford Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. 1 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of John F. Kamm

6 DATE OF BIRTH (month, day, and year) May 27, 1895

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
54	1	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER George Philip Brand

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Mengel

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant John F. Kamm
(Address)

15 Filed ....., 19 C. HAMPSON JONES, M. D.
Registrar

N 12920

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 27, 1928, to June 11, 1929, that I last saw h[illegible] alive on June 11, 1929 and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma Sigmoid

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J S Hedrick, M. D.

, 19 (Address) 4810 Belair Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Emanuel	June 15 19 9
20 UNDERTAKER Louis J Neiman	ADDRESS 32 S Broadway

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46757

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001 E 46757

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. 16-22 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Ennis

(a) RESIDENCE NO. 1007 Whatcoat ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Ennis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Rachel ? 6/12

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Records of
(Address) Baltimore City Hospitals

15 Filed ..., 19 ... Per ... Registrar

C. HAMPSON JONES, M. D.

N 121929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 9, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 6, 1927 to June 9, 1929 that I last saw h... alive on June 9, 1929 and that death occurred, on the date stated above, at 9:15 P.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Old Cerebral Hemorrhage, right

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no What test confirmed diagnosis? Physical Exam

(Signed) M. M. McLane, M. D.

6/12, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	6/12 1929
20 UNDERTAKER	ADDRESS
Samuel T. Hemsley	578 N. Bisel St

important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 46758 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 46758

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1111 Nanticoke St. WARD) 90

REGISTERED NO. 21-29

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie. Catherine Miller

(a) RESIDENCE No. 1111 Nanticoke ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 64 yrs. C mos. 25 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, Widowed, or ~~Divorced~~, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Miller

6 DATE OF BIRTH (month, day, and year): May 17 1863

7 AGE — Years: 64 — Months: C — Days: 25 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Joseph Wiser

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Catherine Becker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs H. W. Keeler

(Address): 1111 Nanticoke St

15 121929 C. HAMPSON JONES, M. D. Registrar

For

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/11/ 1929

17 I HEREBY CERTIFY, That I attended deceased from 1/30/, 1929, to 6/11/, 1929,

that I last saw her alive on 6/11/29, 19

and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) unknown yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? None

(Signed) Bernard J. Tenny, M. D.

6/11, 1929 (Address) 910 W. Lombard St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	June 14 1929
20 UNDERTAKER	ADDRESS
Jos Jourdens Son	2073 Penn

CAUSE OF DEATH to be plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46759

CERTIFICATE OF DEATH

117 E 46759

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Md. General Hospital St.. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Josephine A. Erek

(a) RESIDENCE NO. 1802 Raynor Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — Geo. H. Erek

6 DATE OF BIRTH (month, day, and year) May 20 1889

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min..
	40	0	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work — Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER John H. Ackerman

11 BIRTHPLACE OF FATHER (City or town)

(State or country) N. J.

12 MAIDEN NAME OF MOTHER Josephine H Fellas

13 BIRTHPLACE OF MOTHER (City or town)

(State or country) N. J.

14 Informant

(Address) Hospital Records

15 Filed 19 C. HAMPSON JONES, M.D. Registrar

N 121929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11 19 29

17 I HEREBY CERTIFY, That I attended deceased from 6-2, 19 29 to 6-11, 19 29

that I last saw her alive on 6-11, 19 29

and that death occurred, on the date stated above, at 6:10 P. m.

The CAUSE OF DEATH* was as follows:

Hydro salpinx - Appendicitis

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Paralytic Ileus

(duration) yrs. mos. 6 days

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of 6-5-29

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Jno. M. Gwynn, Jr., M. D.

19 (Address) 1111 Mt. Vernon Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Loudon Park. June-13-1929.

20 UNDERTAKER — ADDRESS

Charles J. Schwab. 505 N. Monroe St.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46760

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 46760

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 329 South Bentalou ST. 20-69 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna Gertrude Kappauf

(a) RESIDENCE NO. 329 South Bentaloust., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John D. Kappauf

6 DATE OF BIRTH (month, day, and year) Nov. 8, 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	7	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Wolfhagen (State or country) Germany

PARENTS

10 NAME OF FATHER Frederick Faber

11 BIRTHPLACE OF FATHER (city or town) Wolfhagen (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Henry Kappauf

(Address) 329 S. Bentalou St.

15 121929 C. HAMPSON JONES, M. D. 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 4, 1929 to June 11, 1929

that I last saw her alive on June 11, 1929

and that death occurred, on the date stated above, at 10.15 P m.

The CAUSE OF DEATH was as follows:

Cystic Teleangiectasis of Myocardium
Hypertension - Chronic Interstitial Nephritis

(duration) June 4 da.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? yes Date of

Was there an autopsy? yes

What test confirmed diagnosis? Clinical

(Signed) Robert E. Tuttle, M. D.

6/17 1929 (Address) 2151 Wilkens Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	June 14 1929
20 UNDERTAKER Joseph B. Cook	ADDRESS 1003 West Baltimore St.

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46761

CERTIFICATE OF DEATH

101-001

E 46761

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 16 E. Lanvale ST. (WARD) 12-19

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Nellie Vincent Wiers

(a) RESIDENCE NO. 16 E. Lanvale ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. 7 mos. 25 ds. How long in U. S., if foreign birth? - yrs. - mos. - ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of William H. Wiers

6 DATE OF BIRTH (month, day, and year) October 16, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	7	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Darby Thompson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Ann O'Neil

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Miss Mary M. Wiers

(Address) 16 E. Lanvale Street

15 [illegible] 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 4, 1929, to June 11, 1929

that I last saw her alive on June 11, 1929

and that death occurred, on the date stated above, at 12 M. m.

The CAUSE OF DEATH* was as follows:

Acute Lobar pneumonia

Splenic Abscess

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? usual

(Signed) F. J. Kirby, M. D.

6/13, 1929 (Address) 1108 Northern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: 6/14 1929

20 UNDERTAKER Henry W. Mears & Son

ADDRESS 805 N. Calvert

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46762

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46762

CERTIFICATE OF DEATH

31

1—PLACE OF DEATH

REGISTERED NO. 12-51

CITY OF BALTIMORE: (No. Baltimore City Hosp ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edward Mann

(a) RESIDENCE NO. 450 W 23rd St ST. City WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mrs Edward Mann

6 DATE OF BIRTH (month, day and year) Dec 9 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	6	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stone cutter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Scotland

PARENTS

10 NAME OF FATHER Peter Mann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant Hosp. Records.

(Address)

15 Filed ..., 19.. Dec 4 1929 C. HAMPSON JONES, M. D. Registrar

N 121929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/10/29

17

I HEREBY CERTIFY, That I attended deceased from April 17, 1924, 19..., to June 10, 1929, that I last saw h... alive on June 10, 1929 and that death occurred, on the date stated above, at 10 00 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum Exam, X-ray

(Signed) Henry Esmuth, M. D.

, 19 (Address) City Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery

DATE OF BURIAL 6/13 1929

20 UNDERTAKER Wm Cook

ADDRESS 417 St Paul

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 46763

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46763

CERTIFICATE OF DEATH.

45

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 502 N. Wash ~~Sinai~~ Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Kirmse

(a) RESIDENCE NO. 502 N. Washington ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M.

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 24 1877

7 AGE Years 51 Months 11 Days 18 12 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Operator

(b) General nature of industry, business, or establishment in which employed (or employer) American Can Co

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country)

PARENTS

10 NAME OF FATHER Adolph Kirmse

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)

12 MAIDEN NAME OF MOTHER Mary Hartwig

13 BIRTHPLACE OF MOTHER (city or town) Germany (State or country)

14 Informant Carlton Brumbley (Address) 502 N. Wash. St.

15 Filed , 19 C. RAMPSON JONES, M. D. Registrar

121929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12 1929

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1929, to June 12, 1929, that I last saw h[illegible] alive on June 12, 1929, and that death occurred, on the date stated above, at 5:45 A. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

Secondary Carcinomatosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of rectum

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of May 25

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) Jos Hopkins M. D.

, 19 (Address) Lewis Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel — DATE OF BURIAL 6/15 1929

20 UNDERTAKER W. S. Cook — ADDRESS 1218 St Paul

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46764

CERTIFICATE OF DEATH

E 46764

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1112 N. Monroe St. 16-22 Ward 90)

2-FULL NAME Mary E. McCormick.

(a) RESIDENCE NO. 1112 N. Monroe St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 Color or Race: White | 5 Single, Married, Widowed or Divorced (write the word): Widow

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of: Elmer S McCormick

6 DATE OF BIRTH (month, day, and year): Sept 7 1855

7 AGE: Years 74 | Months 2 | Days | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town): Md.
(State or country)

PARENTS

10 NAME OF FATHER:

11 BIRTHPLACE OF FATHER (city or town): Md.
(State or country)

12 MAIDEN NAME OF MOTHER:

13 BIRTHPLACE OF MOTHER (city or town):
(State or country)

14 Informant: Mary R. Smedley
(Address) 1112 N. Monroe

15 Filed ....., 19.... C. HAMPSON JONES, M. D. Registrar

121929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 11th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said ..... (Inquest, autopsy or inquiry) find that said deceased came to ..... death on the day stated above.
The CAUSE OF DEATH* was as follows:

I Chronic Myocarditis

(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What tests confirmed diagnosis? Regular

(Signed) A. Leslie Koch, M. D.

June 12 19 29 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — DATE OF BURIAL: 6/13 1929

20 UNDERTAKER: McCook — ADDRESS: 1217 Eutaw

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

N Graves

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46765 — CERTIFICATE OF DEATH — 129 — E 46765

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE (Co.) 2203 N. Charles St. (WARD) 2-50

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Etha St Clair Garber

(a) RESIDENCE NO. 2203 N. Charles St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): April 1 - 1868

7 AGE — Years: 61 — Months: 2 — Days: 10 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Daniel H Garber

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mary L Stauffer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

11 Informant: Donald Garber

(Address) 2203 N. Charles

15 Filed ..., 19... HAMPSON JONES, M. D. Registrar

N 121929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 11 - 29

17 I HEREBY CERTIFY, That I attended deceased from May 1928, 19..., to June 11, 1929, that I last saw h... alive on June 10, 1929, and that death occurred, on the date stated above, at 1 1/4 m.

The CAUSE OF DEATH* was as follows:

(a) Coronary Arterio Sclerosis

(b) Acute Dilatation of Heart

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. K. Graves, M. D.

6/12, 19... (Address) 1122 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: 6/13 29

20 UNDERTAKER: W. M. Cook — ADDRESS: 2113 Eutaw

important. See in-structions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46766

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 46766

1—PLACE OF DEATH

REGISTERED NO. _____

CITY OF BALTIMORE: (No. 2020 Gough ST. 7-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Estella W. Rix

(a) RESIDENCE NO. 2020 Gough ST., _____ WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred _____ yrs. _____ mos. _____ ds. How long in U. S., if foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 26-1898

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	30	8	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 037

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Stanislaus Wyczalek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Gonorata Kawalski

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Vera Rushong

(Address) 2020 Gough St

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

N 121929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11-1929

17 I HEREBY CERTIFY, That I attended deceased from January 0 19 29 to June 11 19 29

That I last saw her alive on June 11 19 29

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis
Myocarditis.

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. Hampson Jones, M. D.

6/12/29 19 (Address) 2020 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus	June 15 19 29

20 UNDERTAKER	ADDRESS
John M Weber	1121 E Chester

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46767

CERTIFICATE OF DEATH

E 46767

1—PLACE OF DEATH

REGISTERED NO. 81

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 3818 Sixth St (Hospital) Brooklyn WARD 25-15

2—FULL NAME Dora Himmel

(a) RESIDENCE NO. 3818 Sixth St Brooklyn WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if foreign birth? 58 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Kasimirus Himmel

6 DATE OF BIRTH (month, day, and year): Oct. 22, 1843

7 AGE: Years 85 | Months 7 | Days 21 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: John Speckman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Theresa Zoellschalk

(Address) 3818 Sixth St Brooklyn

15 Filed: 6/12/1929 Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 12, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 23, 1929 to June 12, 1929

that I last saw her alive on June 11, 1929

and that death occurred, on the date stated above, at 1.10 A.M.

The CAUSE OF DEATH* was as follows:

Acute Pericarditis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary): Arterio Sclerosis

(duration) yrs. mos. unknown ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M A O'Neill M. D.

6/12 1929 (Address) 108 N Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery — DATE OF BURIAL: June 14 1929

20 UNDERTAKER: Margaret E. Flynn — ADDRESS: 1422 Light St

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46768 Roland Ave & Chapel Pky 90 E 46768

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Chadwick Rd (St.) 13-52 (WARD)

2—FULL NAME Webster B. Jones

(a) RESIDENCE NO. 3825 Roland Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Beatrice E. Jones

6 DATE OF BIRTH (month, day, and year) Sept 21-1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Druggist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER John B Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto City

12 MAIDEN NAME OF MOTHER Sarah M. Daniel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Ida Bunting

(Address) 3825 Rolandave

15 Filed JUN 13 1929 C. HAMILTON JONES, M. D. Registrar

N 131923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6. 11. 1929

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1929, to June 11, 1929

that I last saw h~~im~~ alive on June 11, 1929

and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

Rheumatic cardiac disease, aortic insufficiency.

(duration) 15 yrs. mos. ds.

CONTRIBUTORY (Secondary) Auricular fibrillation & cardiac decompensation (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) W H Smith, M. D.

6/12, 1929 (Address) 3429 Chestnut Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	June 13 1929
20 UNDERTAKER	ADDRESS
A S Marshall	2539 Fallsrd

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46769

CERTIFICATE OF DEATH

100-001

E 46769

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2513 N. Lanvale ST. 16-68 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME David W. Abbott

(a) RESIDENCE NO. 2513 W. Lanvale ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 3 mos. 5 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W	S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 2-6-29

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER David R. Abbott

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md.

12 MAIDEN NAME OF MOTHER Josephine C. Hannon

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Md.

14 Informant David R. Abbott

(Address) 2513 N. Lanvale St.

15 Filed JUN 13 1929 Mar

C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-11-29

17 I HEREBY CERTIFY, That I attended deceased from 4-29, 1929, to 6-11, 1929, that I last saw h alive on 6-10, 1929, and that death occurred, on the date stated above, at 10:30 A m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Vernon C. Hart, M. D.

, 19 (Address) 3760 Park Heights Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	June 13 1929

20 UNDERTAKER Patrick A. Hannon

ADDRESS 152 Paloma St

important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

46770

CERTIFICATE OF DEATH.

129 E 46770

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 3564 Poole St. St. 13-57 Ward

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George M. HARE

(a) RESIDENCE. No. 3564 Poole St. St., Ward.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clara L. Hare

6 DATE OF BIRTH (month, day, and year) April 14, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
68	66	1	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer 030

(b) General nature of industry, business, or establishment in which employed (or employer) Stationary

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md.

PARENTS

10 NAME OF FATHER John Hare

11 BIRTHPLACE OF FATHER (city or town) (State or country) md

12 MAIDEN NAME OF MOTHER Mary Bull

13 BIRTHPLACE OF MOTHER (city or town) (State or country) md

14 Informant Clara L. Hare

(Address) 3564 Poole St

15 Filed [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12 1929

17

I HEREBY CERTIFY, That I attended deceased from May 1st, 1929, to June 12th, 1929.

that I last saw h[illegible] alive on June 11th, 1929.

and that death occurred, on the date stated above, at 2.30 A m.

The CAUSE OF DEATH* was as follows:

Acute cardiac dilatation

(Myocarditis)

(duration) yrs. mos. 4/1 ds.

CONTRIBUTORY (Secondary) Chronic duty thrombosis left tibia

Arterial sclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical & Clinical

(Signed) P. A. Fellows, M. D.

6/12 1929 (Address) 3614 Fallsway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem. DATE OF BURIAL: June 15 1929

20 UNDERTAKER: Thanowitch Son ADDRESS: 3615 Chestnut Ave

C. HANSON JONES, M. D.

UN 131929 Per [illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46771

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001

E 46771

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. 22-30 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ethel Smith

(a) RESIDENCE NO. 8 W. York ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Smith

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER Smart Parker

11 BIRTHPLACE OF FATHER (city or town) (State or country) South Carolina

12 MAIDEN NAME OF MOTHER Anna McCleary

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina

14 Informant Records of
(Address) Baltimore City Hospitals

15 Filed 1929 C. HARRISON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 10, 19 29, to June 11, 19 29, that I last saw her alive on June 11, 19 29 and that death occurred, on the date stated above, at 1:45 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Warren H. McLean, M. D.

, 19 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount	June 13 1929
20 UNDERTAKER	ADDRESS
S. E. Brown and Son	1510 W. Baltimore

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46772

155

E 46772

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. St Josephs Hospital ST. 26-41 WARD)

2—FULL NAME Harry Richmond

(a) RESIDENCE NO. 4819 Frankford Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 26-1914

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	14	9	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City Md

PARENTS

10 NAME OF FATHER Max Richmond

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Sophie Rosetzky

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Mrs Richmond
(Address) Roslyn Md

15 Filed JUN 19 1929 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/13/29

17 I HEREBY CERTIFY, That I attended deceased from 6/7/29, 19..., to 6/13/29, 19..., that I last saw him alive on 6/13/29, 19..., and that death occurred, on the date stated above, at 6.20 A m.

The CAUSE OF DEATH* was as follows: Osteomyelitis left tibia

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) septicemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 6/7/29

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W B Hendrix, M. D.

, 19 (Address) St Josephs Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mehren Rosedale	6/13 1929
20 UNDERTAKER Jack Lewis	ADDRESS 1439 E Balto

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 46773

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

~~161-002~~ E 46773

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

Johns Hopkins Hospital.

CITY OF BALTIMORE: (No.) ... ST., 6-9 WARD)

2-FULL NAME Baby Parsons

(a) RESIDENCE No. 433 N. Durham ST. ~~St.~~ WARD ...

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE Black

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 6, 1929

7 AGE Years ... Months ... Days 6 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER William Parsons

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Alma Redmond

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant ... (Address) ...

15 Filed ... 19 ... C. HAMILTON JONES, M. D. Registrar

UN 131929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12 1929

17 I HEREBY CERTIFY, That I attended deceased from 6-6, 1929 to 6-12, 1929

that I last saw him alive on 6-12, 1929

and that death occurred, on the date stated above, at 12.10 A. m.

The CAUSE OF DEATH* was as follows:

Asphyxia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Accidental Trauma

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of ...

Was there an autopsy?

What test confirmed diagnosis?

(Signed) ... M. D.

19 (Address) ...

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cistern Cemetery DATE OF BURIAL Jan 13 1929

UNDERTAKER Robert T. Williams ADDRESS 1515 W. Eldorado St

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46774 E 46774

CERTIFICATE OF DEATH

45

1—PLACE OF DEATH

REGISTERED NO. 16-37

CITY OF BALTIMORE: (No. 3407 Mt. Pleasant ave ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elida H. (Nilsen) Olsen

(a) RESIDENCE NO. 3407 Mt. Pleasant ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Olaf Olsen

6 DATE OF BIRTH (month, day, and year) Oct. 16. 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48	7	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Norway

PARENTS

10 NAME OF FATHER Julius Samuelson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Norway

12 MAIDEN NAME OF MOTHER Anna Olsen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Norway

14 Informant Harry Rehbergn

(Address) 3407 Mt. Pleasant av

Filed JUN 13 1929 19 C. JOHNSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11. 1929

17 I HEREBY CERTIFY, That I attended deceased from April 1927 to June 11 1929, that I last saw her alive on June 11 1929 and that death occurred, on the date stated above, at 5-50 P. m.

The CAUSE OF DEATH* was as follows:

Ischio-rectal cancer

about (duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Diabetis mellitus

about (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of none

Was there an autopsy? no

What test confirmed diagnosis? Physical examination

(Signed) Joseph Rosenblatt M. D.

6/12 1929 (Address) 2018 O'Donnell St. Balto. Md.

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cem	June 4 1929
20 UNDERTAKER	ADDRESS
George W. Sikes	1737 E. Eager st

important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 46775 HEALTH DEPARTMENT—CITY OF BALTIMORE E 46775

CERTIFICATE OF DEATH.

91-002

1-PLACE OF DEATH Home for Incurables

CITY OF BALTIMORE: (No. 46 th St. + Cedar Ave. St. 1-3 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dora Quandt

(a) RESIDENCE No. 619 S. Patterson Pk Ave. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 24, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	71	9	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None (Housemaid)

(b) General nature of industry, business, or establishment in which employed (or employer) 070

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Frederick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER ? Mueller.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Miss Anna Quandt

(Address) 3004 Clifton Park Terrace

15 Filed 6/12, 1929 C. HAMPSON JONES, M. D. Registrar

N 131929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11 1929

17 I HEREBY CERTIFY, That I attended deceased from July 6 — , 1925, to June 11 , 1929

that I last saw her alive on June 11 , 1929

and that death occurred, on the date stated above, at 5.45 p. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis, especially Cerebral

(duration) over 4 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Chronic suppurative cellulitis (duration) — yrs. 3 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Physical diagnosis

(Signed) W W Mayo, M. D.

6/12, 1929 (Address) Medical Arts Building

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem DATE OF BURIAL June 13, 29

20 UNDERTAKER John Leerich ADDRESS 200 E Orleans

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46776

E 46776 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2354 Annapolis St. ST. E. [illegible] WARD)

2—FULL NAME Grace Matthews

(a) RESIDENCE NO. 2354 Annapolis St. ST., [illegible] WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 33 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Stephen Matthews

6 DATE OF BIRTH (month, day, and year) 1896

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER James Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Eliza Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Eliza Thomas
(Address) Baltimore Md

15 Filed 6/13/29 C. HAMPSON JONES, M. D. Registrar

N 131929

important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/10/29

17 I HEREBY CERTIFY, That I attended deceased from 5/22/, 1929, to 6/10/, 1929
that I last saw her alive on 6/8/, 1929
and that death occurred, on the date stated above, at 4. A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

6/10/, 1929 (Address) 912 Eilmont St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Auburn Cem.	6/13 1929
B. UNDERTAKER Daniel Carson	ADDRESS 916 Penna Ave.

Spec.—2-29-28—L. F. S.—500 Bks.

Nelson Brown

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46777

CERTIFICATE OF DEATH

31

E 46777

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST., 7-13 WARD)

2—FULL NAME Nelson Brown

(a) RESIDENCE NO. 1833 Ashland ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1907

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	22			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER Charles Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Viola Portman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

14 Informant Hospital Records

(Address)

15 Filed JUN 13 1929 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7, 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan. 23, 19 29, to June 7, 19 29,

that I last saw him alive on June 7, 19 29,

and that death occurred, on the date stated above, at 9.45 a. m.

The CAUSE OF DEATH* was as follows:

T. B.

Pulmonary T. B.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Henry C. Smith, M. D.

6-7-, 19 29 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
UNIVERSITY OF MARYLAND	19
20 UNDERTAKER	ADDRESS
	JUN 13 1929

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks. Joseph Mc Laughlin

E 46778

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 46778

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST. 3-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph McLaughlin

(a) RESIDENCE NO. 234 S. Dallas st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1897

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER John Mclaughlin

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Mary Francis ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records

(Address)

15 Filed JUN 13 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 23, 1929, to June 7, 1929, that I last saw him alive on June 7, 1929, and that death occurred, on the date stated above, at 11.40 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Henry C Smith M. D.

6-7-, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL 19 1929 JUN

20 UNDERTAKER Geo. A. Deleker Realty

ADDRESS

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46779

CERTIFICATE OF DEATH

129

E 46779

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 328 N Fulton ST. 20-27 WARD)

2—FULL NAME Kate Sadler

(a) RESIDENCE NO. 328 Fulton Av ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 11 1860

7 AGE — Years: 68 | Months: 8 | Days: | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Operator

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: William Sadler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Frederick Md

12 MAIDEN NAME OF MOTHER: Martha Welch

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Alfred F Sadler

(Address): 2381 Fulton Ave

15 [illegible], 19 [illegible] HAMILTON JONES, M. D. Registrar

N 131929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11-29

17 I HEREBY CERTIFY, That I attended deceased from June 8 19 29, to June 11, 19 29, that I last saw h alive on June 11, 19 29 and that death occurred, on the date stated above, at 6 00 a m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Dementia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Guy M Curry, M. D.

6-11 19 (Address) 400 N Payson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Westernbeam — DATE OF BURIAL: June 14 1929

20 UNDERTAKER: Charles H Kechner — ADDRESS: 1732 Hollins

important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46780

CERTIFICATE OF DEATH.

90

E 46780

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 916 (Street) Bennett Pl. (Ward) 18-7

2-FULL NAME Howard Henry

(a) RESIDENCE No. 916 Bennett Pl. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Bessie Henry

6 DATE OF BIRTH (month, day, and year): Aug 2 - 1886

7 AGE: Years 42 | Months 10 | Days 8 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer ohio

(b) General nature of industry, business, or establishment in which employed (or employer): Fertilizer Plant

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country): Middlesex Va.

PARENTS

10 NAME OF FATHER: George Henry

11 BIRTHPLACE OF FATHER (city or town) (State or country): Middlesex Va.

12 MAIDEN NAME OF MOTHER: Lucy Coleman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Gloucester

14 Informant (Address): Jessie Henry 916 Bennett Place

15 Filed JUN 13 1929 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 10 1929

17 I HEREBY CERTIFY, That I attended deceased from May 24, 1929, to June 10, 1929.

that I last saw him alive on June 10, 1929

and that death occurred, on the date stated above, at 8.05 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Valvular heart disease

(duration) ? yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ? yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clin. Exam.

(Signed) Louis T. Levy, M. D.

6/11, 1929 (Address) 1740 W. North ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn

DATE OF BURIAL: 6/13 1929

20 UNDERTAKER: Samuel T. Hemsley

ADDRESS: 5 S. Bond

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46781

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. President & Wash. St. 15-22 Ward)

2-FULL NAME Annie Jeffers

(a) RESIDENCE NO. 1817 Lorman St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Female	Col	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Jos. Jeffers.

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	48			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Va
(State or country)

PARENTS

10 NAME OF FATHER Saml Early.

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Rebecca - Mahone

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant Jos. Jeffers
(Address) 337 W. Lafayette Ave

15 Filed JUN 13 1929, 19 HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, and thereon and from the evidence obtained by said Inquest, and Autopsy (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH was as follows:
(Sheet tear accident)
Hypo. Pneumonia

CONTRIBUTORY (duration) yrs. mos. ds.
Fractured Tibia & Fibula Rt. Leg. Fractured Tibia Lt. Leg.

18 Where was disease contracted (duration) yrs. mos. ds.
If not at place of death? 1200 Block Druid Hill Ave
Did an operation precede death? Yes Date of June 5th
Was there an autopsy? Yes
What test confirmed diagnosis? Autopsy
(Signed) Augustus Blank M. D.
(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Lebanon Cem. DATE OF BURIAL 6/15 1929

20 UNDERTAKER Saml J. Hemsley ADDRESS 5782 Belair

AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

188-002

E 46781

Spec.—2-29-28—L. F. S.—500 Bks. VIANNA. SIBLEY

46782

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

40 E 46782

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. No Balto Gen Hosp ST., ... WARD) REGISTERED NO. 30

2—FULL NAME Mrs. Vianna Sibley

(a) RESIDENCE NO. 118 W. Lee ST., ... WARD
(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clinton Sibley

6 DATE OF BIRTH (month, day, and year) Jan. 14 1898

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
31	4	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Packer

(b) General nature of industry, business, or establishment in which employed (or employer) Nat. Biscuit Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER James Hart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Lillie Owens

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Lillie Hart

(Address) Va.

15 ..... 19 ..... M. JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 17, 19 29 to June 12, 19 29 that I last saw her alive on June 12, 19 29 and that death occurred, on the date stated above, at 1.07 P. m.

The CAUSE OF DEATH* was as follows:

Diffuse Peritonitis
Acute (Mixed Infection)

CONTRIBUTORY (Secondary) Chronic Salpingitis (duration) 2 yrs.

Bilateral (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 17 1929

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Nathan W Cohane M. D.

, 19 (Address) No Balto Gen Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL North End Va

DATE OF BURIAL 6-13 19 29

20 UNDERTAKER Bernard C Hart

ADDRESS Iowa & Rock

Important. See instructions on back of certificates.

N 131929

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46783

CERTIFICATE OF DEATH.

E 46783

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No.) Rutland & Monument ST. 15-68 (WARD) 90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bernard Miller

(a) RESIDENCE NO. 2113 Baker St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 43 yrs. mos. ds. How long in U. S., if of foreign birth? 43 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sadie Miller

6 DATE OF BIRTH (month, day, and year): Sept 12-1884

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
44	9	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Merchant 045

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Abraham Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Mary

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Sadie Miller (Address) 2113 Baker St

15 Filed: 6/13 19 19 C. HAMPSON JONES, M. D. Registrar

N 13029

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/13 19 19

17 I HEREBY CERTIFY, That I attended deceased from 6-10 19 9 to 6-13 19 9

that I last saw h alive on 6-13 19 9

and that death occurred, on the date stated above, at 9:50 m.

The CAUSE OF DEATH* was as follows:

Thrombosis & Coronarytis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): chr myocarditis

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? No

6/13 19 19 (Signed) Bernard Fineberg, M. D.

(Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Southern Ave

DATE OF BURIAL: 6/10 19 9

20 UNDERTAKER: Jack Levis 1439 E Baltimore St

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46784

CERTIFICATE OF DEATH

90

E 46784

REGISTERED NO. 23-37

1—PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Catherine Ruhl

(a) RESIDENCE NO. 1528 Light ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) June 27/66 Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
63 Unknown		11	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Michael Eiler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Records of

(Address) Baltimore City Hospitals

15 6/13/1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11, 1929

17 I HEREBY CERTIFY, That I attended deceased from November 30, 19 28 to June 11, 19 29

that I last saw her alive on June 11, 19 29

and that death occurred, on the date stated above, at 3:30 P.m.

The CAUSE OF DEATH* was as follows:

Arteriosclerotic Heart Disease - Aortic and Mitral Insufficiency

unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) Warren McM. Evans, M. D.

, 19 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park

20 UNDERTAKER Herman Aock

DATE OF BURIAL 6/14 1929

ADDRESS 1219 St. Paul

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46785

CERTIFICATE OF DEATH

E 46785

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2801 Denison ST. (WARD) 15-61

2—FULL NAME Sarah E. Snow

(a) RESIDENCE NO. 2801 Denison ST.. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Snow

6 DATE OF BIRTH (month, day, and year) Jan. 17-1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	4	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carroll Co. Md.

PARENTS

10 NAME OF FATHER Rumrod Burgett

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Rachel Shaffer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Carrie M. Young

(Address) 2801 Denison St.

15 131929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11-1929.

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1929, to June 11, 1929, that I last saw h alive on June 11, 1929 and that death occurred, on the date stated above, at 10.30 P. m.

The CAUSE OF DEATH was as follows:

Apoplexy

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) A. J. Davis, M. D.

6 12 1929 (Address) 800 W 33rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Columbus, Ohio. DATE OF BURIAL June 14-1929

20 UNDERTAKER Horace H. Burgee ADDRESS 3631 Falls Road.

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46786

CERTIFICATE OF DEATH

188-103

E 46786

1-PLACE OF DEATH

City of Baltimore: (No. Johns Hopkins Hosp 6-9 St. Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Leonard Travis

(a) RESIDENCE NO. 232 N Durham St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? [illegible] mos. ds.

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: C

5 Single, Married, Widowed or Divorced, (write the word): Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: [illegible]

6 DATE OF BIRTH (month, day, and year): Feb 10 - 1922

7 AGE: Years 7 | Months 3 | Days 0 | IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Child
(b) General nature of industry, business, or establishment in which employed (or employer): 0
(c) Name of employer

9 BIRTHPLACE (city or town): Balto
(State or country): Md

PARENTS

10 NAME OF FATHER: Chas. Travis

11 BIRTHPLACE OF FATHER (city or town): Balto
(State or country): Md

12 MAIDEN NAME OF MOTHER: Blanche Edmonds

13 BIRTHPLACE OF MOTHER (city or town): Balto
(State or country): Md

14 Informant: Chas Travis
(Address): 232 N. Durham

15 Filed [illegible] 19 C. HAMPSON JONES, M. D. Registrar

N 131929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 10 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows: Fract Skull Leonard Travis came to his death the result of a fractured skull after being struck & run down by an auto driven by Norman Kellam, and the accident was unavoidable & exonerate Kellam

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) automobile struck & run down boy in front of 1802 Orleans

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? in front of 1802 Orleans St

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

6/12 19 29 (Signed) I. Frame, M. D.

(Address) 2939 W. Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	June 14 1929
20 UNDERTAKER	ADDRESS
Milton Davis	413 N Eden St

Spec.—1-12-23—M&T—500 Bks.

E 46787 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-E 46787

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1724 Druid Hill St.) (WARD) 17

2-FULL NAME Irene Soden

(a) RESIDENCE NO. 1724 Druid Hill ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE C

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 20 1911

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
17	7	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Thomas Soden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Irene Sherrod

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N C

14 Informant Thomas Soden

(Address) 1126 Druid Hill

15 Filed 6-13 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11 1929

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1929, to June 11, 1929.

that I last saw her alive on June 10, 1929

and that death occurred, on the date stated above, at 6A m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

CONTRIBUTORY (Secondary) (duration) Acute Bronchitis yrs. mos 10 ds.

18 Where was disease contracted if not at place of death? (duration) yrs. 1 mos. 7 ds.

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thomas Soden M. D.

(Address) 1126 Druid Hill

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Auburn Cem — DATE OF BURIAL 6/14/29

20 UNDERTAKER Chas. H. Alexander — ADDRESS 1401 Druid Hill Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 46788
226125

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 46788

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

2-FULL NAME Harry Kambach Jr.

(a) RESIDENCE No. Salamanca N.Y. ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 3 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	S.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 10/3/16

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	12	8	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... School 8th

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) ..... (State or country) N.Y.

PARENTS

10 NAME OF FATHER Harry

11 BIRTHPLACE OF FATHER (city or town) N Y
(State or country)

12 MAIDEN NAME OF MOTHER Veronica Jones

13 BIRTHPLACE OF MOTHER (city or town) N Y
(State or country)

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed C. HAMPSON JONES, M. D.
Registrar

N 131929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1929

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1929, to June 13, 1929, that I last saw h... alive on June 13, 1929, and that death occurred, on the date stated above, at 3.30 A m.

The CAUSE OF DEATH* was as follows:

Spinal cord tumor - (Sarcoma) Malignant.

..... (duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY
(Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes Date of 11 June 29

Was there an autopsy? .....

What test confirmed diagnosis? Specimen

(Signed) I. Ridgeway Trimble M. D.

June 15 29 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Olean New York — DATE OF BURIAL: June 13 1929

20 UNDERTAKER: Geo M. Frick & Son — ADDRESS: 811 N Wolfe

BEFORE SIGNING BE CAREFUL that ALL ITEMS are correctly supplied. ALL should be filled. PHYSICIANS should be CAUTIONED to be CAREFUL in filling CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46789

E 46789

1-PLACE OF DEATH

City of Baltimore: (No. 755 W. Lexington St., 18 Ward)

2-FULL NAME Herman C. Winchenbach

(a) RESIDENCE NO. 755 W. Lexington St., / Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct. 5- 1872.

7 AGE: Years 56 Months 8 Days 6 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Clerk
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country): Germany

PARENTS

10 NAME OF FATHER: Herman Winchenbach

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Germany

12 MAIDEN NAME OF MOTHER: Henrietta Cook

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Germany

14 Informant: Molley Winchenbach
(Address): Utica, N.Y.

15 Filed ..... 19..... C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): June 11 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Illuminating Gas-
CO Poisoning. Suicide

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zeller M. D.

6/13. 1929. (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Utica New York — DATE OF BURIAL: 6/13 1929

20 UNDERTAKER: John C. Miller — ADDRESS: 2435 E Oliver

N 131929

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 46790. HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46790

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Home for Incurables

CITY OF BALTIMORE: (No. 40th St. & Cedar Ave. ST. 13-52 129 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Eleanora Keene Armstrong

(a) RESIDENCE NO. Home for Incurables ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 1st 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	0	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia ?

PARENTS

10 NAME OF FATHER Jeramiah Armstrong

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Elizabeth Hollingsworth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt. Md. Maryland.

14 Informant (Address) Home for Incurables Resurrection Rd York St

15 Filed 19 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1929

17 I HEREBY CERTIFY, That I attended deceased from Jany 15, 1921 to June 13, 1929 that I last saw her alive on June 13, 1929, and that death occurred, on the date stated above, at 11 05 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis (duration) 6 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Uremia (duration) .. yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Diagnosis

(Signed) W. W. Kay, M. D.

6/13/29 (Address) Medical Arts Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cem. DATE OF BURIAL June 14 1929

20 UNDERTAKER Wm. J. Kieffer & Sons ADDRESS Roseda

N 131929 Dist. 17th

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of [illegible] COPA-TION is very important. See instructions on back of certificates.

Spec.—12-23-21—E.B.R.S.—400 Eks.

E 46791 HEALTH DEPARTMENT—CITY OF BALTIMORE E 46791

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 906 Walnut Ave, St. 28-65 Ward) Registered No. 21

2-FULL NAME Francis Jesse Debes

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) Residence No. 906 Walnut Ave St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, wh.

5-Single, Married, Widowed, or Divorced, (write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Jan 16, 1876

7-AGE. 53 yrs. 4 mos. 26 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Salesman 066

(b) General nature of Industry, business, or establishment in which employed (or employer) Insurance

(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Bolto Md.

PARENTS.

10-NAME OF FATHER, Joseph Debes

11-BIRTHPLACE OF FATHER (city or town) (State or Country), France

12-MAIDEN NAME OF MOTHER, Elizabeth Hinks

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Balto Md

14- (Informant) Katherine E. Joyce

(Address) 906 Walnut Ave

15- Filed C. HAMPSON JONES, M. D., Registrar.

Dist 21

131929

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 12-29

17- I HEREBY CERTIFY, That I attended deceased from June 6 19 29 to June 12 19 29

that I last saw him alive on June 12 19 29

and that death occurred, on the date stated above, at 3.45 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

Cardiac Failure

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(Duration) 3 yrs. mos. ds.

18-Where was disease contracted if not at place of death? unknown.

Did an operation precede death? no Date of

Was there an autopsy? no.

What test confirmed diagnosis? usual signs.

(Signed) Geo. E. Wells, M. D.

19 (Address) 4100 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Greenmount Cem DATE OF BURIAL. June 14 19 29

20-UNDERTAKER. Wm Tuckner Sons ADDRESS N. Y Pa.

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 46792 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 46792

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE (No. 1611 Eareckson ST. 8 WARD)

2-FULL NAME Laura V. Birch

(a) RESIDENCE No. 1611 Eareckson Place ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Clarence Birch

6 DATE OF BIRTH (month, day, and year) April 21, 1871

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
58	1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Clarence Birch. 1611 Eareckson Place

15 C. HAMPSON JONES, M. D. 19.. Registrar

137928

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-12 1929

17 I HEREBY CERTIFY, That I attended deceased from 6/8 or 1929 to 6/12 1929 that I last saw h.... alive on 6/12 1929 and that death occurred, on the date stated above, at 10 30 P m.

The CAUSE OF DEATH* was as follows:

Myocardial degeneration

(duration) yrs. mos 2. ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical signs

(Signed) David Miller M. D.

6/13, 1929 (Address) 1500 Edwin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet — DATE OF BURIAL: June 15 1929

20 UNDERTAKER: Wm Cook — ADDRESS: 1217 St Paul St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46793

CERTIFICATE OF DEATH.

90 E 46793

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hospital WARD 3

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha Campbell

(a) RESIDENCE No. 1371 Woodyear St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	Colored	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of George Campbell

6 DATE OF BIRTH (month, day, and year) 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	39	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland Carbon Hill Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant husband

(Address)

15 C. HAMPSON JONES, M. D. Registrar

N 131929 Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12 1929

17

I HEREBY CERTIFY, That I attended deceased from June 4, 1929, to June 12, 1929, that I last saw h[illegible] alive on June 12, 1929, and that death occurred, on the date stated above, at 6 00 P m.

The CAUSE OF DEATH* was as follows:

Hypertensive Myocardial Decompensation

antecedent Valvular lesion

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) George McDonald M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL June 15 1929

20 UNDERTAKER Clarence E. Wright

ADDRESS 1364 Mary

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46794

CERTIFICATE OF DEATH

E 46794

REGISTERED NO. 11-24

1-PLACE OF DEATH

City of BALTIMORE: (No. Maryland General Hospital (St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph A. Hohman

(a) RESIDENCE NO. 611 Llewellyn Rd (St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Margaret Hohman

6 DATE OF BIRTH (month, day, and year): June 5 1891

7 AGE — Years: 38 Months: Days: 6

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer): Electric Supplies

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Henry A. Hohman

11 BIRTHPLACE OF FATHER (City or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Barbara Litz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant (Address): Hospital Records

C. HAMPSON JONES, M. D. Registrar

Dat

N 131929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: June 11. 1929

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1929, to June 11, 1929,

that I last saw h alive on June 11, 1929,

and that death occurred, on the date stated above, at 10.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder (Cystic)

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hydro-Nephrosis + Uremia Toxemia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of none

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical + autopsy

(Signed) Geo A Jamison M.D.

(Address) The Maryland Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Date of Burial 6/14 1929

20 UNDERTAKER: J. F. Calvert Sons ADDRESS 1518 Eighth St.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state DISEASE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46795

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46795

1—PLACE OF DEATH

REGISTERED NO. 47

CITY OF BALTIMORE: (No. 303 S. Newkirk ST. 16-37 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME EMMA DIETZ

(a) RESIDENCE NO. 303 S. Newkirk ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of George Dietz

6 DATE OF BIRTH (month, day, and year) August 22, 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	9	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER ? Aelshire

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

11 Informant Mr. Oscar Dietz (Son)

(Address) 303 Newkirk Street

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 10-29, to June 13, 1929, that I last saw her alive on June 12, 1929 and that death occurred, on the date stated above, at 3.15 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Left Breast

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) R. H. Hermann, M. D.

June 13 1929 (Address) 2913 E. Balto

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery

DATE OF BURIAL June 15, 1929

20 UNDERTAKER Henry Sander & Sons, Inc.

ADDRESS BALTIMORE ST. & BROADWAY.

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46796

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 46796

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2905 Hudson ST. 1-1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME ERNEST NORDBRUCH

(a) RESIDENCE NO. 2905 Hudson ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of Bertha Nordbruch

6 DATE OF BIRTH (month, day, and year) March 9, 1877

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	52	2 3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bottler

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer G.B.S.Brewery

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Henry Nordbruch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Miss Katherine Nordbruch (Daughter)

(Address) 2905 Hudson Street

15 Filed 1929 C. HAMPSON JONES, M. Registrar

13529

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 7, 1929 to June 11, 1929

that I last saw him alive on June 11, 1929

and that death occurred, on the date stated above, at 5.45 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Cardio Vascular

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Geo. Keller, M. D.

6-12, 1929 (Address) 1937 Gough

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
First Evangelical Cemetery	June 14 1929

20 UNDERTAKER Henry Sander & Sons. Inc.

ADDRESS BALTIMORE ST. & BROADWAY.

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46797

CERTIFICATE OF DEATH

74-801 E 46797

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1904 East 28th ST., 9-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME CAROLINE PORSINGER

(a) RESIDENCE NO. 1904 East 28th ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? 50 yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of George Porsinger

6 DATE OF BIRTH (month, day, and year) April 12, 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	2	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Groemeyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mr. George Porsinger (Husband)

(Address) L 1904 E. 28th St.

15 Filed 6/9 HAMPSON JONES, M. D. Registrar

131929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 29, 19 28, to June 12, 19 29, that I last saw h.. alive on June 11, 19 29 and that death occurred, on the date stated above, at 7.20 a. m.

The CAUSE OF DEATH* was as follows:

1 Hypostatic Pneumonia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. 6 mos. 13 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Alma B Lennan, M. D.

6/10, 1929 (Address) 718 Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL First Evangelical Cemetery

DATE OF BURIAL June 15, 19 29

20 UNDERTAKER Henry Sander & Sons Inc

ADDRESS BALTIMORE ST. & BROA

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

Charles Colvin Becker

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46798

CERTIFICATE OF DEATH

1-PLACE OF DEATH Pronounced Dead at

City of Baltimore: (No. Balt City Hospital St. 1-3 Ward)

2-FULL NAME Charles Calvin Becker

(a) RESIDENCE NO. 704 S Rose St St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

159-902 L

E 46798

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	white	Single

5a If married, widnwed, or divorced
HUSBAND of
(or) WIFE of — — —

6 DATE OF BIRTH (month, day, and year) Aug 8 1926

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or .... min.
	2	7 10	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balt City
(State or country)

PARENTS

10 NAME OF FATHER Charles Calvin Becker

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Pa

12 MAIDEN NAME OF MOTHER Christine Pearson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto Md

14 Informant Charles Calvin Becker
(Address) 704 S Rose St

15 Filed ....., 19.... C. HAMPSON JONES, Registrar

31823 By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Foramen ovale Insufficiency

(duration) 2 yrs. 7 mns. 3 ds.

CONTRIBUTORY (Secondary) Convulsions Due to Pneumonia

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? 704 S Rose St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James H Hamilton, M. D.

June 13 1929 (Address) 700 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery — DATE OF BURIAL June 15 1929

20 UNDERTAKER Henry Sander & Sons Inc — ADDRESS Baltimore St & Broadway

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 46799

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46799

74-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2204 Lake Ave St. 8-45 Ward)

2-FULL NAME Henry . Schmidt

(a) RESIDENCE NO. 2204 Lake Ave St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 9/1889

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	40	4	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Barber
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md

PARENTS

10 NAME OF FATHER Phillip Schmidt

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Bertha Zikelbach

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Wm. Schmidt
(Address) 2204 Lake Ave

15 Filed ..., 19.. C. HAMPSON JONES, M. D. Registrar
Per

131929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:
Probably Apoplexy

(duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary)

(duration) ..yrs. ..mos. ..ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature], M. D.

6/13/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cemetery — DATE OF BURIAL June 14, 1929

20 UNDERTAKER Henry Sander & Sons Inc — ADDRESS Baltimore St. & Broadway

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46800

CERTIFICATE OF DEATH.

101-001

E 46800

1-PLACE OF DEATH

CITY OF BALTIMORE. No. 1614 Madison Ave ST., 4-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theoan Wise

(a) RESIDENCE No. 1614 Madison Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred All yrs. Life ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Herbert A Wise

6 DATE OF BIRTH (month, day, and year) 1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Midwife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER James Murry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Caroline Scott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant (Address) Herbert A Wise

UN 141929 19 C. H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12 1929

17

I HEREBY CERTIFY, That I attended deceased from May-16, 1929, to June 12, 1929, that I last saw h alive on June 12, 1929, and that death occurred, on the date stated above, at 2:25 P m.

The CAUSE OF DEATH was as follows:

Lobar Pneumonia

(duration) yrs. mos 18 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) W. T. Coleman, M. D.

June 13, 1929 (Address) 2039 McCulloh

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem DATE OF BURIAL June 15 29

UNDERTAKER Samuel Hensley ADDRESS 1928 N Bethel

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46801

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

CERTIFICATE OF DEATH

REGISTERED NO. E 46801

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 622 W. Mulberry ST. 17-25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Florence Williams Bailey

(a) RESIDENCE NO. 622 W. Mulberry ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Bailey

6 DATE OF BIRTH (month, day, and year) 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....mln.
	38			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant George Bailey

(Address) 622 W. Mulberry

15 Filed 6/13/29, 19 C. HAMPSON JONES M. D. Registrar

UR 14129

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/12/29

17 I HEREBY CERTIFY, That I attended deceased from 6/11/29, 19 to 6/12/29, 19 that I last saw her alive on 6/12/29, 19 and that death occurred, on the date stated above, at 6.15 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (Primary)

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. Stanley Shiplett, M. D.

6/13, 19 29 (Address) 912 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem.	June 16, 29
20 UNDERTAKER Samuel Hemsley & Bro.	ADDRESS 578 E. Balto.

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 46802

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

E 46802

REGISTERED NO.

1-PLACE OF DEATH

City of Baltimore: (No. 3315 Barclay St. 12-49 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Isaac Johnson

(a) RESIDENCE NO. 3315 Barclay St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elizabeth Johnson

6 DATE OF BIRTH (month, day, and year) 1863

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	64			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Common
(c) Name of employer

9 BIRTHPLACE (city or town) ?
(State or country) North Carolina

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) unknown

14 Informant (Address)

15 Filed ..... 19.. C. HAMPSON BOWIES, M. D. Registrar

By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 11 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest autopsy
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said investigation (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 3315 Barclay

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) James H Parran, M. D.

June 13 1927 (Address) 7 W Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carelry Cem	6/14 1927
20 UNDERTAKER	ADDRESS
Franklin W Sisk	307 E 33rd St

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

46803 E

CERTIFICATE OF DEATH

177 E 46803

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St. 4-30 Ward)

2-FULL NAME Helen Katherine Blatsky

(a) RESIDENCE NO. Delmont, Md. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. / ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 14 - 1927

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	1	11	30	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Delmont, Md

PARENTS

10 NAME OF FATHER Frank Blatsky

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Eva Zilig

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Hungary

14 Informant Katherine Blatsky (Aunt)
(Address) Delmont, Md

15 Filed JUN 14 1929 HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and, from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Strychnine Poisoning
Accidental Death

(duration) yrs. mos. 2 hrs

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Delmont, Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zellers M. D.

6/14, 1929 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Friendship GA Cem DATE OF BURIAL 6/15 1929

20 UNDERTAKER John F Denny ADDRESS 715 E Lt St

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46804

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 46804

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1037 Williams ST. (WARD) 24-33

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Nora E Herpel

(a) RESIDENCE NO. 1037 Williams ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas Herpel

6 DATE OF BIRTH (month, day, and year) Nov 18, 1870

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
58	6	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Wm J Storey

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York City

12 MAIDEN NAME OF MOTHER Emma Kersch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Chas Herpel

(Address) 1037 Mehan Av

15 JUN 14 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 15, 1929, to June 12, 1929, that I last saw h alive on June 12, 1929, and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

Uremia Interstitial Nephritis

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) O Mitchell, M. D.

6/17, 1929 (Address) 1279 Mehan Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cemetery — DATE OF BURIAL 6/14 1929

20 UNDERTAKER Mehan Coon — ADDRESS 1217 St Paul St

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46805

CERTIFICATE OF DEATH

117 E 46805

1—PLACE OF DEATH Hospital REGISTERED NO. 617

CITY OF BALTIMORE: (No. Caroline & Oliver ST., (or) WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Catherine Kingdorf

(a) RESIDENCE NO. 2062 E Oliver ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 3-1894

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	35	3	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) York Co Pa
(State or country)

PARENTS

10 NAME OF FATHER Edward Smith

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Lancaster Pa

12 MAIDEN NAME OF MOTHER Anne E Neely

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore Md

14 Informant Mrs Anne E Smith
(Address) 2062 E Oliver St

15 C. HAMILTON JONES, M. D.
Registrar

N 141929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12-1929

17 I HEREBY CERTIFY, That I attended deceased from 5-19-29, 19..., to 6-12-29, 19...,
that I last saw h alive on 6-12-29, 19...
and that death occurred, on the date stated above, at 10.30 P m.

The CAUSE OF DEATH* was as follows:

Acute Gangrenous Appendicitis

(duration) yrs. mos. 24 ds.

CONTRIBUTORY (Secondary) Bronchio Pneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 5-23-29

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) N B Hendrix, M. D.

, 19 2 (Address) Jewish Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	June 15 1929
20 UNDERTAKER Henry Lutz	ADDRESS 1203 Broadway

important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 46806
1-PLACE OF DEATH

E 46806
REGISTERED NO.

City of BALTIMORE: (No. 1127 Somerset St. 10-14 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Francis Snyder

(a) RESIDENCE NO. 1127 Somerset St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: W

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of ~~or WIFE of~~ Celia Humphy Snyder

6 DATE OF BIRTH (month, day, and year) Not Known

7 AGE: Years: About 61 | Months: | Days: | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town): Balto. Co. (State or country): Md

PARENTS

10 NAME OF FATHER: John Snyder

11 BIRTHPLACE OF FATHER (city or town): (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary Krull

13 BIRTHPLACE OF MOTHER (city or town): (State or country): Germany

14 Informant: Mr. Joseph E. Snyder
(Address) 1127 Somerset St

Filed JUN 14 1929 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19
June 13th 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 26 1926, to June 12 1929, that I last saw him alive on June 12 1929, and that death occurred, on the date stated above, at 7:45 a.m.

The CAUSE OF DEATH* was as follows:

Chr myocarditis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? none

(Signed) A. K. Eicher, M. D.

6/13, 1929 Address) 3421 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery Date of Burial: June 17, 29

20 UNDERTAKER: Henry Roech Sons Inc. ADDRESS: 1301 E Eager St

Tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

46807

CERTIFICATE OF DEATH

90

REGISTERED NO. E 46807

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3200 Northern Parkway (St.) 27-43 (Ward)

2—FULL NAME Mary Ca. Lachenmeyer

(a) RESIDENCE NO. 3600 Northern Parkway ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. — mos. — ds. How long in U. S., if foreign birth? 29 yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow.

6a If married, widowed, or divorced, (HUSBAND) of the late (or) (WIFE) of George Lachenmeyer

6 DATE OF BIRTH (month, day, and year) Nov. 1858

7 AGE: Years 71 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Charles Lappe

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Miss Jon Lostag

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Wm. P. Raymond Cross Landing

(Address) 3200 Northern Parkway

15 Filed JUN 14 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 12 1929

17 I HEREBY CERTIFY, That I attended deceased from Apr. 1928 to June 9 1929

that I last saw h alive on June 9 1929

and that death occurred, on the date stated above, at 6 10 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Mitral Stenosis

Not known (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

Not known (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical exam

(Signed) William A. Johnston M. D.

6/13, 1929 (Address) 2624 St. Paul St.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery

DATE OF BURIAL: June 15 1929

20 UNDERTAKER: Henry Hoeck Sons, Inc.

ADDRESS: 130, E Eager St

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46808 HEALTH DEPARTMENT—CITY OF BALTIMORE 129 E 46808

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 27-48

CITY OF BALTIMORE: (No. 106 Ridgewood Road ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Louzada Sellman

(a) RESIDENCE NO. 106 Ridgewood Road ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 74 yrs. 11 mos. 22 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Annie L. Sellman

6 DATE OF BIRTH (month, day, and year) 6/21/1854

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
74	11	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Alexander Sellman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Hester A Louzada

13 BIRTHPLACE OF MOTHER (city or town) (State or country) London Eng

14 Informant J Archer Sellman

(Address) 106 Ridgewood Rd

15 JUN 14 1929 C. HAMPSON JONES, Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-13-29

17 I HEREBY CERTIFY, That I attended deceased from October, 192~~2~~7, to 6/13, 1927, that I last saw him alive on 6/5, 1927 and that death occurred, on the date stated above, at 3.45 P. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

Chronic Nephritis

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Congestion

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edwin C Ridgely, M. D.

6/13, 1929 (Address) 2.01 N. Madison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	6/15, 1929
UNDERTAKER Henry W. Austin's Sons	ADDRESS ordered by Coulton

IF DEATH from any cause, as result of any injury, occurred under suspicious circumstances, it is important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 46809 HEALTH DEPARTMENT—CITY OF BALTIMORE 101-001 **E 46809**

CERTIFICATE OF DEATH.

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 412 S. Ann St. 2-4 Ward)

2-FULL NAME Stanley A. Podowski Jr.

(a) RESIDENCE NO. 412 S. Ann St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 19-1929

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	—	3	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore md.

(State or country)

PARENTS

10 NAME OF FATHER Stanley A Podowski.

11 BIRTHPLACE OF FATHER (city or town) Balto md.

(State or country)

12 MAIDEN NAME OF MOTHER Matilda Sanzka

13 BIRTHPLACE OF MOTHER (city or town) Poland.

(State or country)

14 Informant Stanley A Podowski.

(Address) 412 S. Ann St.

Filed JUN 14 1929 C. HAMPSON JONES, M. D. Registrar.

Per _____

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to h.s death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) James M Foulon M. D. (Coroner)

6-13, 1929 (Address) 702 Chas St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

St. Stanislaus Cem. June 14 1929

20 UNDERTAKER ADDRESS

George A. Weber 705 S. Ann

Do not write in this space. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46810 HEALTH DEPARTMENT—CITY OF BALTIMORE 5-002 10-

E 46810

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 211 E. Heath ST. 24-34 WARD)

2—FULL NAME George R Johnson

(a) RESIDENCE NO. 211 E Heath ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~ yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Son

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Son

6 DATE OF BIRTH (month, day, and year) Nov. 1, 1922,

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	7	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Richard Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Hermie Riggin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs Hermie Johnson

(Address) 211 E Heath St

15 Filed JUN 14 1929, 19

C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1929

17 I HEREBY CERTIFY, That I attended deceased from May, 1929, to June 13, 1929

that I last saw h alive on June 13, 1929

and that death occurred, on the date stated above, at 3 00 p.m.

The CAUSE OF DEATH* was as follows:

Post Diphtheritic Paralysis

CONTRIBUTORY (Secondary) (duration) 1 yrs. 1 mos. ds. Cardiac Asthma

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. S. L. Campbell M. D.

June 13, 1929 (Address) 1644 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	June 17 1929

20 UNDERTAKER Thos P. Stevens ADDRESS 501 E Fort Ave

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46811 — CERTIFICATE OF DEATH — 164 — E 46811

1—PLACE OF DEATH: Baltimore City Hospitals — REGISTERED NO.

CITY OF BALTIMORE: (No. ____ ST. 72-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME: William Mitchell

(a) RESIDENCE NO. 113 Welcome Alley ST., ____ WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. ____ mos. ____ ds. How long in U. S., if foreign birth? ____ yrs. ____ mos. ____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ____hrs. or ____min.
	81			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Unknown

(b) General nature of industry, business, or establishment in which employed (or employer): ____

(c) Name of employer: ____

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Richard Mitchell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Blanche ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Records of

(Address): Baltimore City Hospitals

15 Filed ____, 19____ H. HARRISON JONES, M. D. Registrar

UN 141929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 12, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 31, 19 29, to June 12, 19 29,

that I last saw him alive on June 12, 19 29

and that death occurred, on the date stated above, at 3:50 P. m.

The CAUSE OF DEATH was as follows:

Senility

(duration) ____ yrs. ____ mos. ____ ds.

CONTRIBUTORY (Secondary) ____

(duration) ____ yrs. ____ mos. ____ ds.

18 Where was disease contracted if not at place of death? ____

Did an operation precede death? no Date of ____

Was there an autopsy? yes

What test confirmed diagnosis? ____

(Signed) [illegible], M. D.

, 19 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cemetery	June 14 1929
20 UNDERTAKER	ADDRESS
Ernest Pree	119 W Hamilton St

Be sure that every question is answered in ink, as this record is important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46812

CERTIFICATE OF DEATH.

31 E 46812

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH 518 N. Linwood Ave.

CITY OF BALTIMORE: (No. ST., 7-11 WARD)

2-FULL NAME James S. White

(a) RESIDENCE NO. 518 N. Linwood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Agnes White

6 DATE OF BIRTH (month, day, and year) June 3, 1881

7 AGE 48 Years | Months | 9 Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Steam-fitter

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER James H. White

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Eliza Ramsey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto, Md

14 Informant Eva Fitzmeyer

(Address) 503 N. Linwood Ave

15 [illegible] C. HAMPSON JONES, M. D.

Registrar

JUN 14 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17 1929

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1929, to June 17, 1929, that I last saw him alive on June 17, 1929, and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? positive sputum

(Signed) L. C. Gobiland M. D.

6/17, 1929 (Address) 474 N. Linwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer | DATE OF BURIAL Jun 15 1929

20 UNDERTAKER J. J. Moran ADDRESS 300 E Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 46813

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46813

CERTIFICATE OF DEATH

1-PLACE OF DEATH Western Electric Plant

City of Baltimore: (No. Colgate Baltimore St. 27-44 Ward)

REGISTERED NO. 185

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Joseph P Martin Jr

(a) RESIDENCE NO. 4910 Marella Rd St., Hamilton Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 19 1907

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	21	7	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Electric Helper
(b) General nature of industry, business, or establishment in which employed (or employer) General Electric
(c) Name of employer H C Crowl Co

9 BIRTHPLACE (city or town)
(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Joseph P Martin

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore

12 MAIDEN NAME OF MOTHER Ann E Wright

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore

14 Informant Ann E Martin
(Address) 4910 Marella

15 Filed ..... 19.... C. HAMPSON JONES, M. D. Registrar

Per

JUN 14 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) March 12 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Jam 7 Medulla Fr
Attby by fall from
step ladder landing on
his head (duration) hr. 5 min.

CONTRIBUTORY (Secondary) Accident

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Wester Elect Plant at Colgate

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) James M Hepburn, M. D.

1929 (Address) 700 Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	6/15 1929
20 UNDERTAKER J A Moran	ADDRESS 3200 E Balto

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46814

HEALTH DEPARTMENT—CITY OF BALTIMORE

164

CERTIFICATE OF DEATH

E 46814

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ST., 5-8 WARD)

2—FULL NAME William A. Whittaker

(a) RESIDENCE NO. Front and Low ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York

PARENTS

10 NAME OF FATHER Asa D. Whittaker

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Johanna Turner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New York

14 Informant Records of

(Address) Baltimore City Hospitals.

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

THE MORGUE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 5, 1929

17 I HEREBY CERTIFY, That I attended deceased from February 11, 19 29, to June 5, 19 29,

that I last saw him alive on June 5, 19 29

and that death occurred, on the date stated above, at 3:15 P. m.

The CAUSE OF DEATH* was as follows:

Senility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no What test confirmed diagnosis? Physical

(Signed) Thomas M. McLean, M. D.

19 (Address) Balto. City Hospitals

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY.

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Commissioner Health.

JUN 14 1929

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46815 — CERTIFICATE OF DEATH — 38 E 46815

1—PLACE OF DEATH Baltimore City Hospitals — REGISTERED NO.

CITY OF BALTIMORE: (No. 22-30 ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Heveler

(a) RESIDENCE NO. 520 Burgundy ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): 040

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Records of

(Address) Baltimore City Hospitals

15 (Date received) JUN 14 1929 C. HAMPSON JONES, M. D. Registrar

THIS MORGUE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 2, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1929, to June 2, 1929, that I last saw him alive on June 2, 1929, and that death occurred, on the date stated above, at 11:55 A. m.

The CAUSE OF DEATH* was as follows:

General Paresis ?

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Wassermann

(Signed) [signature], M. D.

, 19 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
VERSITY OF MARYLAND	19
20 UNDERTAKER	ADDRESS JUN 14 192
Dept. of Public Health.	

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 46816

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46816

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St., 12-19 Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ernest Fastrate

(a) RESIDENCE NO. 1617 N. Calvert ST., WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE: Years 56; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Gardener

(b) General nature of industry, business, or establishment in which employed (or employer): Sanatorium

(c) Name of employer Ude de Turia

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Alexander

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Anna Novak

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Records. (Address) JOHNS HOPKINS HOSPITAL

15 C. HAMPSON JONES, M. D. Registrar

N 141929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-13 1929

17

I HEREBY CERTIFY, That I attended deceased from 5-22, 1929, to 6-13, 1929,

that I last saw him alive on 6-13, 1929,

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Aneurysm of Thoracic aorta

(duration) ? yrs. mos ds.

CONTRIBUTORY (Secondary) Syphilis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) James Bordley M. D.

6/14, 1929 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Humber — DATE OF BURIAL: June 4 1929

20 UNDERTAKER: William F. Schaefer — ADDRESS: 1816 Mmm

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

E 46817 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 129 E 46817

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3001 Fernside Ave ST. 24-29 WARD

REGISTERED NO. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Nathaniel Philetus Kershner

(Residence in Baltimore: No. 3001 Fernside Ave. St.; 24 yrs., mos. ds.)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M

4-COLOR OR RACE. W

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widower

6-DATE OF BIRTH, Aug. 11 (Month) (Day) 1854 (Year)

7-AGE, 74 yrs. 10 mos. 2 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work Real Estate
(b) General nature of industry, business, or establishment in which employed (or employer) Self

9-BIRTHPLACE, (State or Country), Ohio

PARENTS.

10-NAME OF FATHER, James C. Kershner

11-BIRTHPLACE OF FATHER (State or Country), Ohio

12-MAIDEN NAME OF MOTHER Rebecca Eppley

13-BIRTHPLACE OF MOTHER (State or Country), Ohio

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) James A. Kershner

(Address) 3001 Fernside Ave

15-

Filed 141929 C. HAMPSON JONES, M. D. Registrar.

Per

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 13 (Day), 1929 (Year)

17- I HEREBY CERTIFY, That I attended deceased from May 23 1929, to June 13 1929, that I saw him alive on June 13 1929, and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Arteriosclerosis

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Myocardial Degeneration

(Duration) yrs. 1 mos. ds.

(Signed) Howard W. Warner M. D.

6-13, 1929. (Address) 3604 Garrison Av.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Union City Ind

DATE OF BURIAL, 6/15, 1929

20-UNDERTAKER J. H. Woras

ADDRESS 3975 Edison Drive

Spec.—2-29-28—L. F. S.—500 Bks.

E 46818

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 46818

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2500 N. Charles St. ST. 12-57 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Dr. Charles W. McElfresh

(a) RESIDENCE NO. 2500 N. Charles ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	widowed

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Annie Applegarth

6 DATE OF BIRTH (month, day, and year) May 31, 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	No	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) W. Va.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Nannie Green
(Address) 2500 N. Charles St.

15 Filed C. HAMPSON JONES, M. D. Registrar

N 141925

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13.29

17 I HEREBY CERTIFY, That I attended deceased from June, 1927, to June, 1929, that I last saw him alive on June 13, 1929 and that death occurred, on the date stated above, at 4.30 P m.

The CAUSE OF DEATH* was as follows:

Hypertensive Cardio-vascular Renal disease

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? outside

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical Exam

(Signed) Dean Bedon, M. D.

, 19 (Address) 920 N Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	June 15, 1929
20 UNDERTAKER	ADDRESS
John O. Mitchell & Sons, M B Mitchell	1900 Eutaw Pl.

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46819

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 ✓

E 46819

CERTIFICATE OF DEATH

1—PLACE OF DEATH St. Joseph's Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. Caroline & Oliver ST. 8-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles L. Miller

(a) RESIDENCE NO. 1631 N Gay St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 15 192

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	1	10	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Chas. L. Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Helen Blum

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Mrs. Chas. Miller

(Address) 1631 N. Gay St

15 Filed JUN 14 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13/29

17 I HEREBY CERTIFY, That I attended deceased from June 3, 1929, to June 13, 1929.

that I last saw him alive on June 13, 1929

and that death occurred, on the date stated above, at 5 05 P m.

The CAUSE OF DEATH* was as follows:

Hemophilia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) V. Messina, M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Pleasant Valley Westminster	June 16 1929
20 UNDERTAKER Joseph Zepfer	ADDRESS 1600 W. North Ave

important. See instructions on back of certificates.

N 14 1929

Spec.—1-10-21—M&T—1500 Bks.

(Wadding)

22 E-47 1

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46820

CERTIFICATE OF DEATH.

x 135

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Albert Wadding

(a) RESIDENCE NO. Brookville ST., Pa WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Clarinda Wadding

6 DATE OF BIRTH (month, day, and year) 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Ins- Agent-

(b) General nature of industry, business, or establishment in which employed (or employer): Ins Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Penn —

PARENTS

10 NAME OF FATHER Robert Wadding

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Mary - Shumaker

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Reads — (Address) JOHNS HOPKINS HOSPITAL

15 C. HAMPSON JONES, M. D. Registrar

Dar

141929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 1929

17 I HEREBY CERTIFY, That I attended deceased from May 25 1929 to June 14 1929 that I last saw h[illegible] alive on June 14 1929 and that death occurred, on the date stated above, at 12 50 m.

The CAUSE OF DEATH* was as follows:

Benign Prostatic Hypertrophy

Cachexia

Peritonitis

6 mos (duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 324 W 3 Brookville Pa

Did an operation precede death? Yes Date of 5/27/29

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Edward Dempsey, M. D.

, 19 (Address) Johns Hopkins Hosp, Bal

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Brookville, Pa — DATE OF BURIAL: June 14 1929

20 UNDERTAKER: Wm J Denbow — ADDRESS: Brookville Pa

MEDICAL EXAMINER MUST be carefully supplied. AGE should be stated EXACTLY. If UNDER ONE YEAR, state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46821 HEALTH DEPARTMENT—CITY OF BALTIMORE 24-001 E 46821

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals 2-4 REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elnora Novak

(a) RESIDENCE NO. 510 S. Wolfe ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Novak

6 DATE OF BIRTH (month, day, and year) 2/7/1892

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	37	4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records of

(Address) Baltimore City Hospitals

15 Filed 6/14 1929 C. HAMPSON JONES M. D. Registrar

By ....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12, 1929

17 I HEREBY CERTIFY, That I attended deceased from August 10, 1927 to June 12, 1929

that I last saw her alive on June 12, 1929

and that death occurred, on the date stated above, at 2:30 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage, rt

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Hypertension

one years (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical exam

(Signed) Marion M McLane, M. D.

6/12, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem	6/15 1929
20 UNDERTAKER Wm Fraesforelli 1618	ADDRESS Eastern

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46822

E 46822

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. South Baltimore General Hospital ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Augusta Linders

(a) RESIDENCE NO. 1720 N. Washington St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Fred H. Linders

6 DATE OF BIRTH (month, day, and year) Feb 22nd 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	3	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work HOUSEWIFE

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Henry Rau

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elizabeth Schott

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Geo. A. Snopes (Address) 1720 N. Washington St

Filed JUN 14 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13/29

17 I HEREBY CERTIFY, That I attended deceased from April 22, 1929, to June 13, 1929

that I last saw h[illegible] alive on June 10, 1929

and that death occurred, on the date stated above, at 12 35 P.M.

The CAUSE OF DEATH* was as follows:

Carcinoma of Liver

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of May 28, 1929

Was there an autopsy? No

What test confirmed diagnosis? Ex Pleurotomy Laparotomy

(Signed) John G. Oliver M. D.

June 19 (Address) 26-E Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	June 15 19 29

20 UNDERTAKER P. D. Hurlbert ADDRESS 150 N. Eutaw St

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 46823

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 46823

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2540 W. Lombard (St.) 16-68 (Ward) 90

2-FULL NAME August H. Grebe

(a) RESIDENCE NO. 2540 W. Lombard ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced. (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna H. Grebe

6 DATE OF BIRTH (month, day, and year): April 13-1863

7 AGE: Years 66; Months 1; Days 28 29; If LESS than 1 day, ... hrs. or ..min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Farmer 075
(b) General nature of industry, business, or establishment in which employed (or employer): Cattle Business
(c) Name of employer: Himself

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Louis Grebe
11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany
12 MAIDEN NAME OF MOTHER: Margaret Walter
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Ernest Grebe
(Address) 2527 W. Lombard St

15 Filed: JUN 141929
C. HAMPSON JONES, M. D. Registrar
Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): March 11th 1929

17 I HEREBY CERTIFY, That I attended deceased from March 1927, to 11 May 1929, that I last saw h[is] alive on May 11 1929, and that death occurred, on the date stated above, at 9.45 P. m.

The CAUSE OF DEATH* was as follows:

Coronary thrombosis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? Dr. Fletcher

(Signed) Geo. H. Mayer, M. D.

M. 12, 1929 (Address) 2438 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: June 17, 29

UNDERTAKER — ADDRESS

H. S. Shipley, 1850 W. Baltimore St

BURIAL should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46824

CERTIFICATE OF DEATH

48 E 46824

1—PLACE OF DEATH

REGISTERED NO. 67-43

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3126 Glenmore Ave ST., WARD)

2—FULL NAME Peter E. Nostrand

(a) RESIDENCE NO. 3126 Glenmore Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ella F. Nostrand

6 DATE OF BIRTH (month, day, and year): Jan. 15. 1856

7 AGE — Years: 73 | Months: 4 | Days: 28 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Civil Engineer

(b) General nature of industry, business, or establishment in which employed (or employer): Retired 30

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Brooklyn N. Y.

PARENTS

10 NAME OF FATHER: John L. Nostrand

11 BIRTHPLACE OF FATHER (city or town) (State or country): Brooklyn N. Y.

12 MAIDEN NAME OF MOTHER: Ellen McPherson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Brooklyn N. Y.

14 Informant: Arnold K. Caswell

(Address) 3126 Glenmore Ave

15 [illegible] C. HAMPSON JONES, M. D.
Registrar

R 141929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 13. 29

17 I HEREBY CERTIFY, That I attended deceased from May 7, 1929, to June 13, 1929

that I last saw h[illegible] alive on June 13, 1929

and that death occurred, on the date stated above, at 5 [illegible] m.

The CAUSE OF DEATH* was as follows:

Metastatic Tumor of Brain

(duration) yrs. mos. 21 ds.

CONTRIBUTORY (Secondary) Melanotic Sarcoma

Left ear (duration) — yrs. 9 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of May 1929

Was there an autopsy? No

What test confirmed diagnosis? Microscopical

(Signed) Morris B. Greul M. D.

(Address) Hamilton Baltimore Md.

June 14 1929

*State the Disease Causing Death, or In deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cypress Hill - Brooklyn N. Y. DATE OF BURIAL: June 15 1929

20 UNDERTAKER: Wm. Mus. John W. Siepel & Son ADDRESS: 801 W. Fayette

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46825

CERTIFICATE OF DEATH

90 ✓ E 46825

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1223 Carroll ST., 21 WARD)

2—FULL NAME Wilhelmina L. Framer

(a) RESIDENCE NO. 1223 Carroll ST., 21 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if foreign birth 37 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Karl B. L. Framer

6 DATE OF BIRTH (month, day, and year): Jan 13, 1856

7 AGE — Years: 73 | Months: 5 | Days: 0 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): 37

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany.

PARENTS

10 NAME OF FATHER: Henry Starre

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Karl B. L. Framer
(Address) 1223 Carroll St.

15 Filed: C. HAMPSON JONES, M. D. Registrar

N 141929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 13/29.

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1929 to June 13 1929.

that I last saw him alive on June 10 1929

and that death occurred, on the date stated above, at 11 14 a.m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Decompensation.

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Chronic Endocarditis.

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) H. Raymond Wheeler M. D.

6/15, 1929 (Address) Laudoone P.O Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: June 15 1929

20 UNDERTAKER: Mr. & Mrs. J. W. Zepfel & Son — ADDRESS: 801 W. Fayette St.

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 46826

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46826

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. U. S. Marine Hospital Ft. 12-51 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ramon Canis

(a) RESIDENCE NO. 225 Garfield st N-4 ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 21, 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	9	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work fireman 086

(b) General nature of industry, business, or establishment in which employed (or employer) Seaman

(c) Name of employer SS Philadelphia

9 BIRTHPLACE (city or town) (State or country) British West Indies

PARENTS

10 NAME OF FATHER Joseph Canis

11 BIRTHPLACE OF FATHER (city or town) (State or country) British W. Indies

12 MAIDEN NAME OF MOTHER Caterina Peters

13 BIRTHPLACE OF MOTHER (city or town) (State or country) British W. Indies

14 Informant Clinical Records U. S. (Address) Marine Hospital

15 FILED JUN 14 1929 C. HAMPSON JONES, M. D. Registrar

BY

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12 1929

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1929, to June 12, 1929, that I last saw h[illegible] alive on June 12, 1929, and that death occurred, on the date stated above, at 9 0 m.

The CAUSE OF DEATH* was as follows:

Syphilis tertiary

(duration) yrs. ?, mos. ds.

CONTRIBUTORY (Secondary) Valvular disease of heart, mitral + aortic

(duration) yrs. ?, mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical + laboratory

(Signed) Rudolph T Porter, M. D.

, 19 (Address) U. S. Marine Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery DATE OF BURIAL June 15, 1929

20 UNDERTAKER E. Leroy Stiffler & Inc. ADDRESS 125 E. North ave

INFORMATION SHOULD BE GIVEN BY PERSON BEST QUALIFIED TO FURNISH CORRECT AND COMPLETE ANSWERS. PHYSICIANS should fill in CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 46827 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46827.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 908 N. Carey St., (WARD) 16-23 46

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lorrin Tomlinson

(a) RESIDENCE NO. 908 N. Carey ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 29 1868

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
61	5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Rock Driller

(b) General nature of industry, business, or establishment in which employed (or employer) Quarry

(c) Name of employer Mr. Wagner.

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Tomlinson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Lorrin Hudson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Amanda Tolson

(Address) 908 N. Carey St.

15 C. HAMPSON JONES, M. D. Registrar

141929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/17 1929

17 I HEREBY CERTIFY, That I attended deceased from 4/17 1929, to 6/17 1929, that I last saw h alive on 6/17 1929, and that death occurred, on the date stated above, at 11:00 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Cervix Uteri

(duration) 1 yrs. 4 mos ds.

CONTRIBUTORY (Secondary) Toxemia from Cancer (duration) 1 yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? —

What test confirmed diagnosis? Clinical

Signed) W. H. Lee Gibbs M. D.

19 (Address) 924 Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn DATE OF BURIAL June 15 1929

20 UNDERTAKER Thomas E. Wright ADDRESS 364 Carey

INFORMATION should be carefully supplied. Age should be stated EXACTLY. Literal CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46828
1—PLACE OF DEATH

31 E 46828
REGISTERED NO.

CITY OF BALTIMORE: (No. 1376 West North ST. 19 WARD 59

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret Brayden

(a) RESIDENCE NO. 1376 West North ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Brayden

6 DATE OF BIRTH (month, day, and year) Nov 12

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	67	7	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) ohh

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Dirkin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Anna Stanton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Margaret Brayden
(Address) 1376 W. North Ave

15 141929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14-29.

17 I HEREBY CERTIFY, That I attended deceased from May 26 19 29 to June 14 19 29.

that I last saw her alive on June 13 19 29

and that death occurred, on the date stated above, at ...m.

The CAUSE OF DEATH* was as follows:

Intercalvis Carcinomatis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Obvious signs

(Signed) E. McCahan, M. D.

6/14, 19 29 (Address) 111 E Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL 6/17 19 29

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46829

CERTIFICATE OF DEATH

E 46829

1—PLACE OF DEATH

REGISTERED NO. 47

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3008 Christopher ST. WARD)

2—FULL NAME Augusta A. Langley

(a) RESIDENCE NO. 3008 Christopher ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 14 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

If married, widowed, or divorced: HUSBAND of (or) WIFE of: Albert F. Langley

6 DATE OF BIRTH (month, day, and year): March 3 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	3	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Philadelphia

PARENTS

10 NAME OF FATHER: Christian Lang

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Augusta Muller

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mary Reeves

(Address) 3008 Christopher

15 Filed ..... 19 .....

C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 14-29

17 I HEREBY CERTIFY, That I attended deceased from June 1 . 1929 to June 14 . 1929.

that I last saw h[er] alive on June 13 . 1929

and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Carcinomatosis

Original focus L. breast. (duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Philadelphia

Did an operation precede death? Yes Date of 1928

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jos J Kunzig M. D.

6/14 . 1929 (Address) 2700 Howard St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oakwood Cemetery

DATE OF BURIAL: 6/17 1929

20 UNDERTAKER: William Cook

ADDRESS 1217 St Paul

important. See instructions on back of certificates.

N 141929

Spec.—2-29-28—L. F. S.—500 Blks.

Dr Shreve
408 Patterson Park Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46830

CERTIFICATE OF DEATH

14-09 E 46830

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 635 S Curley ST. 1-2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret Schaller

(a) RESIDENCE NO. 635 S Curley ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Henry Schaden

6 DATE OF BIRTH (month, day, and year) Nov 30, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Miss Lillian DeSadyn

(Address) 635 S Curley St

15 Filed 6/17 19 29 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14, 1929

I HEREBY CERTIFY, That I attended deceased from June 4, 19 29, to June 14, 19 29

that I last saw h alive on 6 13, 19 29

and that death occurred, on the date stated above, at 6 20 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

CONTRIBUTORY (Secondary) Hypertension (duration) yrs mos 10 ds.

(duration) yrs mos ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) C. Shreve M. D.

6/17/29 (Address) 408 E Pat Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel — DATE OF BURIAL June 16 1929

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul St

important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 46831 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

45 E 46831

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH 424 N. Curley St.

CITY OF BALTIMORE: (No. 424 N. Curley St. ST. 6-11 WARD)

2-FULL NAME Rose Chada

(a) RESIDENCE NO. 424 N. Curley St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? 52 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	W	widow

5a If married, widowed, or divorced (~~HUSBAND of~~) (or) WIFE of Frank Chada

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Own

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cuba Havana

PARENTS

10 NAME OF FATHER Joseph Kenwood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Cuba Havana

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Cuba Unknown

14 Informant Louis Schafer

(Address) 424 N. Curley St

N 151929 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 1929

17 I HEREBY CERTIFY, That I attended deceased from 12/26, 1928, to June 14, 1929, that I last saw h[illegible] alive on June 13, 1929, and that death occurred, on the date stated above, at 12:30 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of ascending colon

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) L. C. Sobieski M. D.

6/14, 1929 (Address) 447 N. Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer DATE OF BURIAL June 17 1929

20 UNDERTAKER Knox Croxton ADDRESS 916 Wash

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46832

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 46832

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 715 N. Chapel ST. 7-13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sophia Conrad

(a) RESIDENCE NO. 715 N Chapel ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 76 yrs. mos. ds. How long in U. S., if foreign birth? 76 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

.a If married, widowed, or divorced HUSBAND of (or) WIFE of Fred Conrad

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Hecker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Fred Conrad

(Address) 715 N Chapel St

15 JUN 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12/29

17 I HEREBY CERTIFY, That I attended deceased from April 2, 1929 to June 12, 1929.

that I last saw her alive on June 12, 1929

and that death occurred, on the date stated above, at 5.45 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 1 yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? C

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Joseph Pokorny, M. D.

, 19 (Address) 220 E Madison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL June 15 19 29

20 UNDERTAKER Ernest Graefen — ADDRESS Woodlawn

important: See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Blks.

E 46833 HEALTH DEPARTMENT—CITY OF BALTIMORE

161-E 46833

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3205 Sun St. 25-76 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James Charles Schultz

(a) RESIDENCE No. 3205 Sun St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Infant.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Baby

6 DATE OF BIRTH (month, day, and year) 6-6-29

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or....min.
	X	X	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant. and

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer X

9 BIRTHPLACE (city or town) Fairfield

(State or country) 3205 Sun St.

PARENTS

10 NAME OF FATHER James Schultz

11 BIRTHPLACE OF FATHER (city or town) Md.

(State or country) USA

12 MAIDEN NAME OF MOTHER Mary Swadoska

13 BIRTHPLACE OF MOTHER (city or town) Bohemia

(State or country)

14 Informant James Schultz

(Address)

151929 (1929) CAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/14 1929

17 I HEREBY CERTIFY, That I attended deceased from 6/6 1929, to 6/14 1929.

that I last saw him alive on 6/13 1929.

and that death occurred, on the date stated above, at 930 a. m.

The CAUSE OF DEATH* was as follows: Bronchopneumonia

Cause of death

Mal Nutrition

(duration) yrs. — mos 8 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. X mos. X ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? No Date of X

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

, 19 (Address) 1340 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross	June 15 1929
20 UNDERTAKER	ADDRESS
Funeral Direction	1915 Edmondson

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Bks.

E 46834

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46834

CERTIFICATE OF DEATH.

X 155

28-65

1-PLACE OF DEATH Kernan Hospital.

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

2-FULL NAME Ruby Greenberg.

(a) RESIDENCE NO. Belmont Rd. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan 26 1912

7 AGE: 12 Years | 4 Months | 27 Days | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Girl.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Clive Greenberg.

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Alma Gardner.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant I M Creager

(Address) Thurmont Md

15 C. HAMPSON JONES, M. D. Registrar

By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 1929

17

I HEREBY CERTIFY, That I attended deceased from March 30, 1929, to June 14, 1929.

that I last saw her alive on June 14, 1929,

and that death occurred, on the date stated above, at 8:25 a.m.

The CAUSE OF DEATH* was as follows:

Osteomyelitis.

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Post operative pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? Yes Date of June 11 29

Was there an autopsy? No

What test confirmed diagnosis? Clinical Laboratory.

(Signed) Clement K Norman, M. D.

, 19 (Address) Kernan Hospital. Catonsville Balto Co

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Thurmont Md — DATE OF BURIAL 6/17/29

20 UNDERTAKER: William Cook — ADDRESS 1217 St Paul

N 51929

REGISTRATION OF DEATHS IS COMPULSORY. AGE should be stated EXACTLY. PHYSICIANS should fill CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 22 40835 HEALTH DEPARTMENT—CITY OF BALTIMORE E 46835

CERTIFICATE OF DEATH. X 44

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 7-9 (WARD)

2-FULL NAME Mary L. Smith

(a) RESIDENCE NO. British Columbia ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Smith

6 DATE OF BIRTH (month, day, and year): 1875

7 AGE: Years 54; Months; Days; If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: W.W. 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): England

PARENTS

10 NAME OF FATHER: Sinclair

11 BIRTHPLACE OF FATHER (city or town) (State or country): Engd

12 MAIDEN NAME OF MOTHER: ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Engd

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

15 JUN 15 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 14 1929

17

I HEREBY CERTIFY, That I attended deceased from April 8, 1929, to June 14, 1929, that I last saw her alive on June 14, 1929, and that death occurred, on the date stated above, at 11 55 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of oesophagus with invasion of trachea.

(duration) yrs. 5 mos 2 ds.

CONTRIBUTORY (Secondary): Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of Apr. 9-1929

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) G. B. Strud. M. D.

June 14 1929 (Address) Johns Hopkins Hosp. Baltimore Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Washington D.C. DATE OF BURIAL: June 15 1929

20 UNDERTAKER: W.W. Deal ADDRESS 816 H St NW Wash DC

mation should be carefully supplied. AGE should be stated EXACTLY. If UNKNOWN, state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46836 HEALTH DEPARTMENT—CITY OF BALTIMORE E 46836

CERTIFICATE OF DEATH

74-001

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 345 Longwood St. WARD) 21-29

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Fannie F. Lee

(a) RESIDENCE NO. 345 Longwood St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. 11 mos. 20 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Wm. B. Lee.

6 DATE OF BIRTH (month, day, and year) June 24th 1875

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
54	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work house work.

(b) General nature of industry, business, or establishment in which employed (or employer) /

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John Conway

11 BIRTHPLACE OF FATHER (~~city or~~ town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Margaret Mc Guire

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant John F. Lee

(Address) 345 Longwood St

15 Filed 6/14 19 29 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13th 1929.

17 I HEREBY CERTIFY, That I attended deceased from Feb 3 19 29, to June 13 19 29, that I last saw h alive on June 11 19 29 and that death occurred, on the date stated above, at 11.30 A m.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 4 mos. 10 ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No What test confirmed diagnosis? Physical findings

(Signed) John L. Kelly M. D.

19 (Address) 1729 E. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem.	June 17th 1929.
20 UNDERTAKER John F. Howard & Son.	ADDRESS 901 Hollins

important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 46837

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 46837

REGISTERED NO.

1-PLACE OF DEATH Church Home + Infirmary

City of BALTIMORE: (No. Broadway + Fairmount 12 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME ~~John~~ Frederick Nauman

(a) RESIDENCE NO. 416 E. 22nd St. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Marie E. Nauman

6 DATE OF BIRTH (month, day, and year): July 24 1873

7 AGE: Years 55 | Months 10 | Days 28 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto. (State or country) Md

10 NAME OF FATHER John Nauman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary E. Spreck

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

PARENTS

14 Informant Mrs. Marie E. Nauman

(Address) 416 E 22nd St

Filed ..... 19 C. HAMPSON JONES, M. D.

By ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 1929

17 I HEREBY CERTIFY, That I attended deceased from June 4, 1929, to June 14, 1929

that I last saw him alive on June 14, 1929

and that death occurred, on the date stated above, at 2:14 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage

(duration) ..... yrs. ..... mos. 11 ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) ..... yrs. ..... mos. 2 ds.

18 Where was disease contracted

If not at place of death? Lauren Jail

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Walter B. Johnson, M. D.

June 14 1929 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

New Cathedral Cemetery June 18 1929

20 UNDERTAKER ADDRESS

Henry Koeck Sons, Inc. 1301 E Eager St.

Use should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46838

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46838

CERTIFICATE OF DEATH

74-001

1—PLACE OF DEATH

REGISTERED NO. 16-23

CITY OF BALTIMORE: (No. 605 N. Calhoun ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emma Harriton Newnam

(a) RESIDENCE NO. 605 N. Calhoun ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

6 DATE OF BIRTH (month, day, and year): Aug. 8 1855

7 AGE: Years 73 | Months 10 | Days 5 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Churchhill Md.

PARENTS

10 NAME OF FATHER: Wm V. Sparks

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Ann E. Harriton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mr. Wm S. Newnam
(Address): 605 N. Calhoun St.

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 13, 1929

17 I HEREBY CERTIFY, That I attended deceased from October, 19 27, to June 13th, 19 29, that I last saw h[illegible] alive on June 13, 19 29, and that death occurred, on the date stated above, at 8.30 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Involving and Ruptured
Brain down condition more

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Coma and Exanustion

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Charles A Davis, M. D.

, 19 (Address) 2108 Brookfield Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Crumpton Queen Anne's Co. Md	June 15, 1929
20 UNDERTAKER	ADDRESS
Wm J. Fickner Sons	North Pa

important. See instructions on back of certificates.

N 151 [illegible] HARRISON JONES, M. D.

Spec.—2-29-28—L. F. S.—500 Blks.

E 46839

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46839

CERTIFICATE OF DEATH

90

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 714 N. Luzerne ST., 7-12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Patrick anderson

(a) RESIDENCE NO. 714 N Luzerne ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Lost

6 DATE OF BIRTH (month, day, and year) June 1 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	—	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Trucker

(c) Name of employer B & O R R.

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER John anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Cahill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs Catherine Brannon

(Address) 714 N. Luzerne (Sister)

15 [illegible] 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13. 1929

17 I HEREBY CERTIFY, That I attended deceased from June 6 1929, to June 13. 1929.

that I last saw h[illegible] alive on June 12. 1929

and that death occurred, on the date stated above, at 3 00 P. m.

The CAUSE OF DEATH* was as follows:

Acute Dilation Heart

(duration) yrs. mos. 4 hrs

CONTRIBUTORY (Secondary) Mitral Regurgitation Decompensated

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Thos. F. Stearns, M. D.

6/14. 1929 (Address) 2878 Hartford Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	June 17 1929
20 UNDERTAKER Chas. L. Stearns	ADDRESS 1502 E Fort Ave

important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46840

CERTIFICATE OF DEATH

E 46840

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 203 N Arlington Ave St. 16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha Jefferson

(a) RESIDENCE NO. 203 N Arlington Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 Color or Race: Col'd

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or.) WIFE of: Samuel Jefferson

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE: Years 37 Months Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer

9 BIRTHPLACE (city or town): Georgia

(State or country)

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (City or town)

(State or country)

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country)

14 Informant: Oliver Ford

(Address) 502 Bradley Av

15 Filed ....., 19 .....

Registrar

151929

HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 12 19 29

17 I HEREBY CERTIFY, That I attended deceased from June 12, 1929, to June 12, 1929, that I last saw h alive on June 12, 1929, and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yr. mos. 1 da.

CONTRIBUTORY (Secondary): Putrid Cellulitis

(duration) yrs. mos. 1 da.

18 Where was disease contracted if not at place of death? Ho

Did an operation precede death? Date of Ho

Was there an autopsy?

What test confirmed diagnosis?

(Signed) June 13 1929 J. Woodward, M. D.

(Address) 934 W Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery — Date of Burial: June 15, 1929

20 UNDERTAKER: Mrs. Katie R. Williams — ADDRESS 322 N. Schroeder St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 46841

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129-E 46841

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 313 E Cross ST. 24-33 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Cora Busick

(a) RESIDENCE NO. 313 E Cross ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. 3 mos. 12 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fmal	W	Widow

a If married, widowed, or divorced HUSBAND of (or) WIFE of George Busick

6 DATE OF BIRTH (month, day, and year) March 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	3	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework at

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER James Jervis

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Hester Madison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs Ella F Cripps

(Address) 313 E Cross St

15 Filed HAMPSON JONES, M. D. 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13/1929

17 I HEREBY CERTIFY, That I attended deceased from June 7/29, 19, to June 13/29, 19, that I last saw her alive on June 13/29, 19, and that death occurred, on the date stated above, at 11-15 P m.

The CAUSE OF DEATH* was as follows:

Nephritis

Pneumonia (duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis & High Blood Pressure

Pneumonia (duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Henry B Kolb, M. D.

June 17/29 (Address) 1703 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	June 17 1929
20 UNDERTAKER	ADDRESS.
John F Denny	715 Lexington St

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46842

CERTIFICATE OF DEATH

10-002

E 46842

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Sydenham Hospital) 16-34 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Violet Brill

(a) RESIDENCE NO. 3622 Esther Pl. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. 1 mos. 11 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 3, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	5	1	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Brill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Ethel Wilson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Esther Brill

(Address) 3622 Esther Place

Filed JUN 15 1929 C. HAMPSON JONES, M. D. Registrar

important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 14, 1929, to June 14, 1929,

that I last saw h alive on June 14 1929

and that death occurred, on the date stated above, at 5:30 m.

The CAUSE OF DEATH* was as follows:

Diphtheria (Nasal, Tonsillar & Pharyngeal)

(duration) 0 yrs. 0 mos. 4 ds.

CONTRIBUTORY (Secondary) Acute Diphtheritic Myocarditis (duration) 0 yrs. 0 mos. 1 ds.

18 Where was disease contracted if not at place of death? 3622 Esther Pl

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Addison Craft Clark M. D.

6-15 1929 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkton Md. Cremation	19 29
20 UNDERTAKER	ADDRESS
Lilly & Sons Inc.	403 N. Howard St

Spec.—2-29-28—L. F. S.—500 Bks.

E 46843

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001

E 46843

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1508 Eastern Ave. WARD) 3rd

2—FULL NAME Helen Sutton

(a) RESIDENCE NO. 1508 Eastern Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: C.

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 5, 1929

7 AGE: Years | Months: 7 2 | Days: 12 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Kedah Sutton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lancaster Va.

12 MAIDEN NAME OF MOTHER Irene Young

13 BIRTHPLACE OF MOTHER (city or town) Balto. Md. (State or country)

14 Informant Irene Sutton

(Address) 1508 Eastern Ave.

15 Filed 19

C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/14/29

17 I HEREBY CERTIFY, That I attended deceased from 6-14, 1929, to 6-14, 1929, that I last saw him alive on 6-14 1929 and that death occurred, on the date stated above, at 11:30 a. m.

The CAUSE OF DEATH* was as follows:

Acute Bronchial Pneumonia

(Marasmus

(Malnutrition)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? yes

What test confirmed diagnosis? Clinical

(Signed) W. B. Rucker, M. D.

, 19 (Address) 425 N. Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary — DATE OF BURIAL: June 5, 1929

20 UNDERTAKER: Mrs. R. G. Elliott — ADDRESS: 1225 Ashland Ave

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46844

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001

E 46844

CERTIFICATE OF DEATH

REGISTERED NO. 76-29

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 812 S. Eaton ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME 5 month foetus LeBrun

(a) RESIDENCE NO. 812 S. Eaton ST., 26 WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, bosiness, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Edward LeBrun

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Dorothy Thompson

13 BIRTHPLACE OF MOTHER (city or town) Ghent P.O. Md
(State or country)

14 Informant Mrs Dorothy LeBrun
(Address) 812 S. Eaton St

15 Filed 19 C. HAMPSON JONES, M.D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 7/29

17 I HEREBY CERTIFY, That I attended deceased from June 7, 1929, to June 7, 1929, that I last saw h in alive on June 7, 1929, and that death occurred, on the date stated above, at 9 a.m. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Observation

(Signed) Horace B. Sellman, M. D.

6/15, 1929 (Address) 315 S Hoyt Lund Dem

*State the Disease Causing Death, or in deaths from Violent Caoses, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Johns Hopkins Emb. Dept	6/9th 1929
20 UNDERTAKER	ADDRESS

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46845 HEALTH DEPARTMENT—CITY OF BALTIMORE

123 E 46845

CERTIFICATE OF DEATH

1—PLACE OF DEATH University Hospital REGISTERED NO. 16-37

CITY OF BALTIMORE: (No. Lombard & Greene ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Flora Condelis

(a) RESIDENCE NO. 421 - 14th ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Greek White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mick. Condelis

6 DATE OF BIRTH (month, day, and year): May 16/1903

7 AGE: Years 26 | Months | Days 28 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Homemaker

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Greece.

PARENTS

10 NAME OF FATHER: A. Fokenos

11 BIRTHPLACE OF FATHER (city or town) (State or country): Greece.

12 MAIDEN NAME OF MOTHER: Flora Fokenos

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Greece.

14 Informant: Mick. Condelis

(Address) 421. S. 14. st.

15 [illegible] 19 C. HAMPSON JONES, M. D. Registrar

151929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6-14-29

17 I HEREBY CERTIFY, That I attended deceased from 6-7, 1929, to 6-14, 1929, that I last saw her alive on 6-14, 1929 and that death occurred, on the date stated above, at 3 pm. m.

The CAUSE OF DEATH* was as follows:

Acute Cholecystitis
Cholelithiasis

(duration) months yrs. mos. ds.

CONTRIBUTORY (Secondary): Bronchopneumonia (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? Yes Date of 6-9-29

Was there an autopsy? no Removal of gall bladder

What test confirmed diagnosis? Clinical & operation

(Signed) Henry Vincent Davis, M. D.

6/14. 1929 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemty. DATE OF BURIAL: June 15 1929.

20 UNDERTAKER: Geo. F. Rust ADDRESS: 1735 Harford

important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 4084 HEALTH DEPARTMENT—CITY OF BALTIMORE E 46846

CERTIFICATE OF DEATH.

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1114 L Bond St. Ward) 26-2

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Joseph Klemiatof

(a) Residence No. 1114 L Bond St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced, (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 14 1929

7-AGE. ....yrs....mos....ds. If LESS than 1 day, 1 hrs. or....min.*

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country),

PARENTS.

10-NAME OF FATHER. Fadej Klemiatof

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Russia

12-MAIDEN NAME OF MOTHER. Anna Zoltka

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Russia

14- (Informant) Father

(Address) 1114 L Bond St.

15- C. HAMPSON JONES, M. D. Registrar.

N 151929

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). 6-15-29

17- I HEREBY CERTIFY, That I attended deceased from 6-15-29, 19.. to 6-15-29 19..,

that I last saw him alive on 6-15-29, 19..,

and that death occurred, on the date stated above, at 1:40a.m.

The CAUSE OF DEATH* was as follows:

Asphyxia neonatorum

1 hour

(Duration) ...yrs...mos...ds.

CONTRIBUTORY (Secondary) Maternal dystcia owing to breech presentation.

(Duration) ...yrs...mos...ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) I. B. Bronushas, M. D.

6-15-29 (Address) 3037 O'Donnell St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Queen of Heaven Cath. Cem. Holy Trinity DATE OF BURIAL. June 14 1929

20-UNDERTAKER. Stefan J. Fialkowski Inc. ADDRESS 1000 S. Kenwood Ave.

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46847

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-901

E 46847

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 916 Augusta ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ora Lee Gaines

(a) RESIDENCE NO. 916 Augusta ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	C.	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1905

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
23	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) N. E. Dispensary

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Geo. W. Gaines

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Laurettachase

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Annetta Pleasant
(Address) 1020 E. Madison St

15 Filed 6-15-29 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-13-29

17 I HEREBY CERTIFY, That I attended deceased from 6/5, 1929, to 6-13, 1929
that I last saw h alive on 6/13/29, 19
and that death occurred, on the date stated above, at 12 20 P. m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchiectasis

(duration) yrs. 1 mos. 20 ds.

18 Where was disease contracted if not at place of death? H

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) Jas. R. Blake, M. D.

6/14, 1929 (Address) 924 Augusta St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cem	6-16 1929

20 UNDERTAKER ADDRESS

Byron & Knight 1218 McCulloh

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46848

CERTIFICATE OF DEATH

161-001

E 46848

1-PLACE OF DEATH

REGISTERED NO. 19-27

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of Baltimore: (No. 212 N. Gilmor St., 19 Ward)

2-FULL NAME Infant Allen

(a) RESIDENCE NO. 212 N. Gilmor St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
		Five Hours	5

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) 212 N Gilmor St

PARENTS

10 NAME OF FATHER Louis Johnson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore

12 MAIDEN NAME OF MOTHER Fannie E. Allen

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Pa.

14 Informant Victoria Pinnell
(Address) 5 13 Rodman St

15 Filed 19 SIGNED C. HAMPSON JONES, M.D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Premature Birth
(about 7 mo)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. O'B. Brooke M. D.

June 15 1927 (Address) 3601 3rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Zion Cemetery	June 15, 1927
20 UNDERTAKER	ADDRESS 322 N Schroeder St
Mrs. Katie R. Williams	

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46849

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46849

CERTIFICATE OF DEATH

10-15-90

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1105 Brentwood Ave ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret V. Rosensteel

(a) RESIDENCE NO. 1105 Brentwood Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 24, 1863

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
65	5	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER J. Leo Rosensteel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Frances Gold

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant Miss Constance Rosensteel

(Address) 1105 Brentwood Ave

15 151929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13/29

17 I HEREBY CERTIFY, That I attended deceased from Jan 1 1929, to June 13, 1929, that I last saw h[illegible] alive on June 13, 1929 and that death occurred, on the date stated above, at 11-45 A m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms.

(Signed) W. M. Peace, M. D.

6-14, 1929 (Address) 1 West Pleasant St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	June 17, 1929

20 UNDERTAKER Bela Friedfeld ADDRESS 914 Hanover Ave

important. See instructions on back of certificates.

Spec.—2-29128—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46850

CERTIFICATE OF DEATH

E 46850

1—PLACE OF DEATH Balto City Hospl

REGISTERED NO. 77-43

CITY OF BALTIMORE: (No. Balto 2nd St., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rudolph Klitch

(a) RESIDENCE NO. 2710 Fleetwood Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 11th 1870

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
59	6	2 / 1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Machinist

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Klitch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Balto City Hospl

(Address) Balto Md

15 Filed ....., 19.... C. HAMPSON JONES, M. D. Registrar

N 151929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-13-29

17 I HEREBY CERTIFY, That I attended deceased from 5-1-, 19 29 to 6-13, 19 29

that I last saw h.. live on 6-13, 19 29

and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Terminal Bronchopneumonia

Myocardial failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Psychosis c Cerebral arterio sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical findings

(Signed) Henry Goodman M. D.

6/14, 19 29 (Address) Balto City Hospls.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery — DATE OF BURIAL 6/17 19 29

20 UNDERTAKER E. J. Fanning & Son - 1938 E. Lafayette Ave — ADDRESS

IMPORTANT.—Before pallbearers, or any of the property claimed, leave statement of occurrence is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46851

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-081

E 46851

1—PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO.

CITY OF BALTIMORE: (No. 76-37 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Andrena Henson

(a) RESIDENCE NO. 319 S. Lehigh ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Hans Henson

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Norway

PARENTS

10 NAME OF FATHER: Olsen ?

11 BIRTHPLACE OF FATHER (city or town) (State or country): Norway

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Norway

14

Informant: Records of

(Address) Baltimore City Hospitals

Filed ..... 19 ..... HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 12, 1929

17

I HEREBY CERTIFY, That I attended deceased from June 7, 1929 to June 12, 1929, that I last saw her alive on June 12, 1929 and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage, right

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) W. M. McLean, M. D.

19 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cy	June 15 1929
20 UNDERTAKER: Wendell J. Leppel	ADDRESS: 3004 Eden

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 46852

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001

E 46852

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 707 Cumberland St. (Ward) 15-21

2-FULL NAME Alice Peal.

(a) RESIDENCE NO. 707 Cumberland St. Ward .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Fmle	Col	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Peal

6 DATE OF BIRTH (month, day, and year) Nov 12-1865

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	63	7	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laundress.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) & State) Md.
(State or country)

PARENTS

10 NAME OF FATHER Chas. Green

11 BIRTHPLACE OF FATHER (city or town) & State) Md
(State or country)

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) & State) Md
(State or country)

14 Informant Georgie Parker
(Address) 707 Cumberland St

15 Filed ..... 19.. THOMPSON JONES, M. D. Registrar

N 151929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 12th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ..... yrs. ..... mos. 7 ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Regular.

(Signed) H. Holtzinck, M. D.

June 19 29 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	June 16 1929

20 UNDERTAKER Thomas E. Kelson

ADDRESS 1303 Bernstman St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

E 46853

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 46853

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 825 N. Calhoun St. 16-23 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Dorcas Wallace

(a) RESIDENCE NO. 825 N. Calhoun St. ✓ Ward ✓

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. ✓ mos. ✓ ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? ✓ yrs. ✓ mos. ✓ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced (or) WIFE of: Henry Wallace

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 51 | Months ✓ | Days ✓ | IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country): Calvert County Md.

PARENTS

10 NAME OF FATHER: George White

11 BIRTHPLACE OF FATHER (City or town) (State or country): Unknown.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: George H. Wallace

(Address) 825 N Calhoun St

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 12 - 1929

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1929, to June 12, 1929, that I last saw h[er] alive on June 11, 1929, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Nephritis Chronic

(duration) 1 yrs. ✓ mos. ✓ ds.

CONTRIBUTORY (Secondary): Coma

(duration) 1 yrs. ✓ mos. 1 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No.

What test confirmed diagnosis? Clinical methods

(Signed) George E. Shannon, M. D.

6/13 1929 (Address) 701 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Owen Sta Calvert Co Md — Date of Burial: Jun 16 1929

20 UNDERTAKER: Thomas E. Kelan. — ADDRESS: 1130 Pressman St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

151929

C. HAMPSON JONES, M. D.

Spec.—1-10-21—M&T—1500 Bks.

E 46854 (224894) HEALTH DEPARTMENT—CITY OF BALTIMORE E 46854

CERTIFICATE OF DEATH. X 49

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. 7-9 WARD)

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gussie Danziger

(a) RESIDENCE NO. 2242 Tiebout Ave New York City ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. 24 ds. How long in U. S., If of foreign birth? 38 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Aaron Danziger

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Isaac Brothes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Ella —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL—PSON JONES, M

15 Filed JUN 15 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15 1929

17 I HEREBY CERTIFY, That I attended deceased from April 28, 1929, to June 15, 1929, that I last saw her alive on June 15, 1929, and that death occurred, on the date stated above, at 3.40 A m.

The CAUSE OF DEATH* was as follows:

Brain tumor, malignant

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Apr. 15, 1929

Was there an autopsy? Removal of tumor

What test confirmed diagnosis?

(Signed) I. Ridgeway Trimble, M. D.

June 15 29 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New York City DATE OF BURIAL 6/15 1929

20 UNDERTAKER Fred Levis ADDRESS 1429 E Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. If under one year or over one hundred years, the number of months or days. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 46855

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46855

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 310 N. Bruce St., 14-27 Ward) 61-602

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Burley

(a) Residence No. 310 N. Bruce St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Black

5-Single, Married, Widowed, or Divorced. (Write the word.) Se

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 14 '29

7-AGE. ....yrs. ....mos. ....ds. If LESS than 1 day, ...hrs. or 15 min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. None

(b) General nature of industry, business, or establishment in which employed (or employer). do

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country), 310 N. Bruce St.

PARENTS.

10-NAME OF FATHER, Richard Burley

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Harmonie Maryland

12-MAIDEN NAME OF MOTHER, Mary Butler

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Dawson Maryland

14- (Informant) Richard Burley

(Address) 310 N. Bruce St

15- Filed ....., 19.. WILLIAM H. HAMILTON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) 6/14/29

17- I HEREBY CERTIFY, That I attended deceased from June 14, 1929 to June 14 1929 that I last saw h.. alive on June 14 1929 and that death occurred, on the date stated above, at 8.35A m.

The CAUSE OF DEATH* was as follows:

Intra-Cranial Hemorrhage

(Duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

6/14 1929 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL.

Mount Olivet June 15 1929

20-UNDERTAKER. ADDRESS

Joseph A Lively 1092 Mount St

in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46856

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46856

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 26-20

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3225 Kenyon Ave ST., WARD)

2—FULL NAME Frank Stuney

(a) RESIDENCE NO. 3225 Kenyon ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Eva Stuney

6 DATE OF BIRTH (month, day, and year) Feb. 28, 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Copper Works

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Michael Stuney

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Teresa Clement

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Mrs Katherine Stuney

(Address) 3225 Kenyon ave

15 Filed ....., 19.... Registrar

15823 THOMPSON JONES, M.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13-1929

17 I HEREBY CERTIFY, That I attended deceased from June 12, 1929, to June 13 1929.

that I last saw h. alive on June 12, 1929

and that death occurred, on the date stated above, at 7 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of Stomach

(duration) 1 yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Sept. 1928

Was there an autopsy? No

What test confirmed diagnosis? Operation & autopsy

(Signed) J Sheldon Faustman M. D.

, 19 (Address) 823 Medical Arts Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cem	June 16 1929
20 UNDERTAKER John Merrick	ADDRESS 2008 Aliceanna

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46857

CERTIFICATE OF DEATH

90 E 46857

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2522 Fleet ST. 13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elise Reutter

(a) RESIDENCE NO. 2522 Fleet ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Fritz Reutter

6 DATE OF BIRTH (month, day, and year): Nov 24-1856

7 AGE: 72 Years | Months: 6 | Days: 20 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Fredk Von Segern

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Sophia Von Segern

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Henry D. Reutter

(Address) 2022 Fleet St

15 Filed 1 5 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 14-1929

17 I HEREBY CERTIFY, That I attended deceased from June 1st, 1929, to June 14th, 1929, that I last saw h[illegible] alive on June 14th, 1929 and that death occurred, on the date stated above, at 12 25 a m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Embolism

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

June 14, 1929 (Address) 1906 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem

DATE OF BURIAL: June 17, 1929

20 UNDERTAKER: John Ulrich

ADDRESS: 2008 Aliceanna

Spec.—1-12-23—M&T—500 Blks.

E 46858 HEALTH DEPARTMENT—CITY OF BALTIMORE E 46858

CERTIFICATE OF DEATH. 160

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 512 E. North Ave ST.) 9-14 (WARD)

2-FULL NAME John Sennwalt Mason Jr.

(a) RESIDENCE NO. 512 E. North Ave

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

WARD

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): June 8, 1929

7 AGE — Years: — Months: — Days: 6 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: J. S. Mason

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: M. K. Dorcas

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: J. S. Mason

(Address) 828 N. Broadway

15 Filed , 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 14 1929

17

I HEREBY CERTIFY, That I attended deceased from June 8, 1929, to June 14, 1929, that I last saw him alive on June 14, 1929 and that death occurred, on the date stated above, at 2.30 P. M.

The CAUSE OF DEATH* was as follows:

Asthenia Neonatorum

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary): —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Edwin H. [illegible], M. D.

6/15, 1929 (Address) 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet — DATE OF BURIAL: 6/15 1929

20 UNDERTAKER: Robert Brooks & Son — ADDRESS: Calhoun & Hollins St

Spec.—1-10-21—M&T—1500 Bks.

E 46859 HEALTH DEPARTMENT—CITY OF BALTIMORE E 46859

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Howard A. Kelly Hospital Inc. ST. 14-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME George E. Black.

(a) RESIDENCE No. Winchester Kentucky ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. 3 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Black.

6 DATE OF BIRTH (month, day, and year) [illegible].

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kentucky

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Hospital Records

(Address)

15 JUN 16 1929 C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15 1929

17 I HEREBY CERTIFY, That I attended deceased from March 9, 1929, to June 15, 1929, that I last saw him alive on June 15, 1929, and that death occurred, on the date stated above, at 10 am m.

The CAUSE OF DEATH* was as follows:

Carcinomatosis primary in testicle

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Dilatation heart.

(duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death? Mount Sterling, Ky.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Pathological

(Signed) William Reid Jr., M. D.

6-15-1929 (Address) 1416 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Winchester Kentucky DATE OF BURIAL June 16 1929

20 UNDERTAKER Chas. S. Black ADDRESS 742 W. North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

46860 HEALTH DEPARTMENT—CITY OF BALTIMORE E 46860

CERTIFICATE OF DEATH. 90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 650 George ST. 17-24 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rachel Olver (Oliver)

(a) RESIDENCE No. 650 George ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colord	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
99	78			

8 OCCUPATION OF DECEASED None

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) M D

PARENTS

10 NAME OF FATHER Joseph Bell

11 BIRTHPLACE OF FATHER (city or town) (State or country) M D

12 MAIDEN NAME OF MOTHER Julia Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) M D

14 Informant Solomon Oliver

(Address) Range mill Baltimore Co

15 JUN 16 1929 19 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 1929

17 I HEREBY CERTIFY, That I attended deceased from 1-6-, 1929, to 6-14-29 19, that I last saw h alive on 6-14-29, and that death occurred, on the date stated above, at 7.40 P m

The CAUSE OF DEATH* was as follows:

Mitral Insufficency

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Gastritis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. R. Boykin, M. D

, 19 (Address) 1512 Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Claiborne MD DATE OF BURIAL June 16 1929

20 UNDERTAKER Edward Bryan ADDRESS 1631 Orleans

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46861 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 46861

CERTIFICATE OF DEATH

1—PLACE OF DEATH Latrobe Apts. REGISTERED NO. 11-15 40

CITY OF BALTIMORE: (No. Cor. Read & Charles ST. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Robert E. Lee Goldsborough

(a) RESIDENCE NO. Latrobe Apartments ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 28th 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Wholesale Textile

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Hesslein & Co. New York

9 BIRTHPLACE (city or town) (State or country) Talbot Co Maryland

PARENTS

10 NAME OF FATHER Nicholas Goldsborough

11 BIRTHPLACE OF FATHER (city or town) Talbot Co (State or country) Maryland

12 MAIDEN NAME OF MOTHER Lavinia Turner Carter

13 BIRTHPLACE OF MOTHER (city or town) Virginia (State or country)

14 Informant C. H. Goldsborough

(Address) 20 Fifth Ave New York

15 [illegible] 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15/29

17 I HEREBY CERTIFY, That I attended deceased from Jan 12th, 1929, to Jan 15th, 1929

that I last saw him alive on Jan 15th, 1929

and that death occurred, on the date stated above, at 1.20 P m.

The CAUSE OF DEATH* was as follows:

Cor. Acute Dilatation of Heart. Myocarditis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. B. Hamilton M. D.

, 19 (Address) 24 W Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oxford Md	June 16 1929

20 UNDERTAKER Henry H. Hankins & Son ADDRESS Oxford Md

OF DEATH in plain terms, so that it may be properly classified. Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46862

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46862

CERTIFICATE OF DEATH

REGISTERED NO. 129

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1022 E Monument ST. 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Geo L. Stanley

(a) RESIDENCE NO. 1022 E Monument ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Married

a If married, widowed, or divorced HUSBAND of (or WIFE of) Rose K Stanley

6 DATE OF BIRTH (month, day, and year) 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Postmaster

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer U.S. Postal Service Balto Md

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Josiah Stanley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant J. Edgar Stanley son

(Address) 1022 E Monument St

15 [illegible]

JUN 16 1929 C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14, 1929

17

I HEREBY CERTIFY, That I attended deceased from March, 1929, to June 14, 1929, that I last saw h in alive on June 13, 1929 and that death occurred, on the date stated above, at 8:15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis slight Moderate Hypertension

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R J Young, M. D.

6/15 1929 (Address) 1429 E Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	6-17-1929
20 UNDERTAKER	ADDRESS
Mrs Chas G. Bailey	1431 Jefferson St

important. See instructions on back of certificates.

Spec'a—1-10-21—M&T—1500 Bks.

E 46863 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 46863

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Motherhouse of Notre Dame ST. 10-14 WARD)

2-FULL NAME Sister Mary Johanna Schmidt

(a) RESIDENCE NO. 901 Aisquith Street ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 18, 1863

7 AGE: Years 65 Months 11 months Days 26 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher 065

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Religious

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER John Schmidt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Elisabeth Burkert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) York Pa.

14 Informant School Sisters of Notre Dame (Address) 901 Aisquith Street

15 JUN 16 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14, 1929

17 I HEREBY CERTIFY, That I attended deceased from February 15 . 1929 . to June 14 . 1929 , that I last saw her alive on June 14 . 1929 , and that death occurred, on the date stated above, at 12:30 P.M. m.

The CAUSE OF DEATH* was as follows—

Arteriosclerosis-
Chr Nephritis - Hypertension
Cerebral hemorrhage

(duration) yrs. 4 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? yes

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? usual

(Signed) F. J. Kirby, M. D.

6/15, 1929 (Address) 1106 Northern

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Notch Cliff Rd. DATE OF BURIAL: June 17 1929

UNDERTAKER: Frank A. Fink ADDRESS: 910 N. Gay St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46864 E 46864

CERTIFICATE OF DEATH

16-69 57

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2423 Harlem Ave. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thomas Meyers Barth,

(a) RESIDENCE NO. 2423 Harlem Ave. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) July 26.1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	10	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Coach Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Christian Barth,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary M.Kraft,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Mrs E Shields

(Address) 2423 Harlem Ave

15 Filed 1929 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY, That I attended deceased from May 27. 1929. to June 15. 1929.

that I last saw h alive on June 14. 1929.

and that death occurred, on the date stated above, at 6 A m.

The CAUSE OF DEATH* was as follows:

acute Nephritis &
Myocarditis

(duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) years yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) D. L. Long Attnr M. D.

19 (Address) 4700 Frederick Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ Loudon Park

DATE OF BURIAL 19

20 UNDERTAKER Geo W Lutz

ADDRESS

important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

Alfred C. Wagner

E 46865

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 46865
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Alfred C. Wagner ST., 7-17 WARD)

2-FULL NAME 1116 N Fulton ave

(a) RESIDENCE NO. Same ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. 5 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, or ~~Divorced~~, (write the word)
White	Male	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ida C Wagner

6 DATE OF BIRTH (month, day, and year) 1-17-1876

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	54	5	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Christian Wagner (about)

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto

12 MAIDEN NAME OF MOTHER None

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant John Wagner
(Address) 1415 Hughlands ave

15 Filed ....., 19.... C. HAMILTON JONES, M. D. Registrar

UN 161929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 19 29

17 I HEREBY CERTIFY, That I attended deceased from May 6, 1929, to June 14, 1929, that I last saw him alive on June 13, 1929 and that death occurred, on the date stated above, at 12 m

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis -

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Nephritis -

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W. S. Gray, M. D.

6/15 19 29 (Address) 6 W 7th, Mt Vernon

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rood Cem DATE OF BURIAL June 17 1929

20 UNDERTAKER Jos J Herr & Son ADDRESS 156 Fulton

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46866

CERTIFICATE OF DEATH.

E 46866

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Balto. City Hosp ST. OR AVE. WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Wm Armacost.

(a) RESIDENCE NO. Upperco Md ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 3-1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26	10	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Insurance.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Co.

PARENTS

10 NAME OF FATHER J. F. Armacost

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Matilda F Wolfe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Geo. Armacost

(Address) Upperco Md

15 [illegible] C. HARRISON JONES, M. D. Registrar

UN 16 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15 1929

17 I HEREBY CERTIFY, That I attended deceased from June 13, 1929, to June 15, 1929.

that I last saw h[illegible] alive on June 15, 1929

and that death occurred, on the date stated above, at 7:45 P. m.

The CAUSE OF DEATH* was as follows:

Gangrenous ruptured Appendix with [redacted] Generalized Abscess

(duration) yrs. 11 mos 6 ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Y Date of June 14 1929

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Operative

(Signed) Benj. S Abrahim M. D.

, 19 (Address) West Balto. City Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Prospect cemetery Balto

DATE OF BURIAL June 18 1929

20 UNDERTAKER Edw C Kepton

ADDRESS Homestead Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Bain

HEALTH DEPARTMENT—CITY OF BALTIMORE

46867

CERTIFICATE OF DEATH.

49 E 46867

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 409 Orleans St. (Hospital, Institution or Street) 20-28 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Esther Bain

(a) RESIDENCE NO. 409 Orleans ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 ~~Single, Married~~, Widowed, or ~~Divorced (write the word)~~ Widowed

5a ~~If married, widowed, or divorced~~ ~~HUSBAND OF~~ (or) WIFE of Jacob Bain

6 DATE OF BIRTH (month, day, and year) Jan. 1, 1876

7 AGE Years 53 Months 5 Days 15 If LESS than 1 day, ... hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER (?)

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER (?)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Mr. Bear Bain (son)

(Address) 2106 Reisterstown Rd

15 Filed JUN 16 1929 C. HAMILTON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15, 1929

17 I HEREBY CERTIFY, That I attended deceased from Mar. 14, 1929, to June 15, 1929.

that I last saw her alive on June 14, 1929

and that death occurred, on the date stated above, at 8.15 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Malignancy

(probably Carcinoma Lung)

approximately

(duration) 1 yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) A. Allen Brosman M. D.

, 19 (Address) 2340 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Northern Circle Cem DATE OF BURIAL 6/16 1929

20 UNDERTAKER Jack Lewis ADDRESS 1439 E Balt St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46868

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46868
REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 838 South Paca ST. 12-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Herman Schneider

(a) RESIDENCE NO. 838 South Paca ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Barbara

6 DATE OF BIRTH (month, day, and year) Sept 1 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	9	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blacksmith

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Barbara Schneider
(Address) 838 South Paca

15 (Filed) JUN 16 1929 WILLIAM R. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15-29

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1929, to June 15, 1929, that I last saw him alive on June 14, 1929 and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis.

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Apoplexy (duration) yrs. 1 mos. 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical ex

(Signed) J. M. Schnepper, M. D.

June 16 1929 (Address) 3409 Callaway Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL 6/18 1929

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul

important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 46869

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91 E 46869

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor ST. 10-14 WARD)

2-FULL NAME Mesinne. Eickenberg

(a) RESIDENCE No. Preston + Valley ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry

6 DATE OF BIRTH (month, day, and year) March 4-1835

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min
	94	2	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Henry Mesinne

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Dina Eicke

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant (Address) Little Sisters of the Poor Preston + Valley St

JUN 16 1929

HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 15 June 1929

17 I HEREBY CERTIFY, That I attended deceased from 6/13, 1929, to 6/15, 1929, that I last saw her alive on 6/14, 1929, and that death occurred, on the date stated above, at 12 30 P. m.

The CAUSE OF DEATH* was as follows:

Senility
arteriosclerosis
unknown (duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm B Magruder M. D.

6/15/29 (Address) 121 S Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Patterson Cemetery

UNDERTAKER William Coots

DATE OF BURIAL 6/17 1929

ADDRESS 121 S Paca

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46870

E 46870

CERTIFICATE OF DEATH

100-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5503 Craig Ave ST., 21-H WARD

2—FULL NAME Elizabeth Wolterecke

(a) RESIDENCE NO. 5503 Craig Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Gustav

6 DATE OF BIRTH (month, day, and year): Oct 16-1863

7 AGE: Years 65 | Months 7 | Days 28 29 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Gustav Wolterecke

(Address) 5503 Craig Ave

15 Filed JUN 16 1929, 19 HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 14-29

17 I HEREBY CERTIFY, That I attended deceased from June 12, 19 29, to June 14, 19 29

that I last saw her alive on June 14, 19 29

and that death occurred, on the date stated above, at 8 20 P m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

4

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edgar L. Sandrock, M. D.

, 19 (Address) Medical Arts Building

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loraine Cemetery — DATE OF BURIAL: 6/17 1929

20 UNDERTAKER: William Cook — ADDRESS: 1217 Eutaw

For

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

46871

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 46871

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 52 Old Orchard Rd ST.) 28-71 (WARD) 90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Lambeth Shaw

(a) RESIDENCE NO. 52 Old Orchard Road ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas K. Shaw

6 DATE OF BIRTH (month, day, and year) Jan 12 1862

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	67	5	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington, D.C.

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Jane Shemwell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Thomas L. Shaw

(Address) Baltimore, Md

C. HAMILTON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15, 1929

17

I HEREBY CERTIFY, That I attended deceased from June 15, 1928, to June 15, 1929,

that I last saw her alive on June 15, 1929,

and that death occurred, on the date stated above, at 8 4 m.

The CAUSE OF DEATH* was as follows:

Myocarditis Chronic,

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene L. Cronin M. D.

6.15. 1929 (Address) 54 Drury Lane

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Westminster, Md. DATE OF BURIAL June 18 1929

20 UNDERTAKER F. O. Shaum & Son ADDRESS Westminster Md.

JUN 19 1929

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44 V

E 46872

E 46872
1—PLACE OF DEATH

REGISTERED NO. 27-48

CITY OF BALTIMORE: (No. 6023 Bellona Ave. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Niedwig

(a) RESIDENCE NO. 6023 Bellona ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Niedwig

6 DATE OF BIRTH (month, day, and year): April 2. 1864

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
65	2.	13.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Shoe Maker.

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: John Niedwig

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Marguerite Hermann

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mary Niedwig (Address) 6023 Bellona ave.

15 [illegible] C. HARRISON JONES, M. D. Registrar

JUN 16 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 15-1929.

17 I HEREBY CERTIFY, That I attended deceased from April 2, 1928, to June 15, 1929.

that I last saw him alive on June 15, 1929

and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver, large intestines.

Metastasis of lungs.

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): Pneumonia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-Ray & Clinical findings

(Signed) S. W. Bishop, M. D.

(Address) 521 Edmondson.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	June 17 1929.

20 UNDERTAKER: Mrs. John F. Seidel & Son ADDRESS: 801 W. Fayette St.

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 46873

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

X 100-001 E 46873

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No.) Monument + Rutland ST. 7-13 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edwin A. Parker

(a) RESIDENCE NO. Harlem Lane & Old Frederick Road Catonsville, Md. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. - mos. - 7 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Grace E. Wright

6 DATE OF BIRTH (month, day, and year) Dec. 23, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	8	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work President

(b) General nature of industry, business, or establishment in which employed (or employer) Parker Metal

(c) Name of employer Decorating Company

9 BIRTHPLACE (city or town) (State or country) Fort Scott, Kansas Mo.

PARENTS

10 NAME OF FATHER John T. Parker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ohio

12 MAIDEN NAME OF MOTHER Mary C. Zimmerman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not obtainable

14 Informant Mrs. Grace E. Parker

(Address) Catonsville, Md.

15 Dec 16 1929 C. HAMILTON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-14 1929

17 I HEREBY CERTIFY, That I attended deceased from 6-7 1929, to 6-14 1929, that I last saw him alive on 6-14 1929, and that death occurred, on the date stated above, at 10 15 P m.

The CAUSE OF DEATH* was as follows:

Septicaemia (Staphylococcus aureus haemolyticus)

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) H. H. Slaver, M. D.

1929 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL 6/17 1929

20 UNDERTAKER Henry W. Mears & Son — ADDRESS 805 N. Calvert

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should write CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46874

CERTIFICATE OF DEATH.

E 46874

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 120 S. Castle ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Casimer Sasnauckas

(a) RESIDENCE NO. 120 S. Castle ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of: Helen Bayon Sasnauckas

6 DATE OF BIRTH (month, day, and year): Mar 4 1892

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
37	3	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER: Pieta Sasnauckas

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Lothuna

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant (Address): Helen Sasnauckas 120 S. Castle St

15 Date JUN 16 1929 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 13 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 9 13, 1927 to June 12 1929

that I last saw h alive on June 12 1929 and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary): Arteriosclerosis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J. Rauch, M. D.

1929 (Address) 8012 Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer

DATE OF BURIAL: 6/17 1929

20 UNDERTAKER: J. J. Moran

ADDRESS 320 E Baltimore

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

Belle Christian

E 46875 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

12 E 46875

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 617 Redwood (St.) 4-30 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Belle Christian

(a) RESIDENCE NO. ~~1917~~ 617 Redwood ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John L Christian

6 DATE OF BIRTH (month, day, and year): Feb 14 1884

7 AGE: Years 45 Months 3 Days 24 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic 037

(b) General nature of industry, business, or establishment in which employed (or employer): Housework

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Thomas Burnes

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Belle Burnes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Hattie Eager

(Address): 617 Redwood St

15 Filed JUN 16 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6 — 13 — 1929

17 I HEREBY CERTIFY, That I attended ~~deceased~~ from April 10th, 19 29, to June 13th, 19 29, that I last saw h~~im~~ alive on June 12th, 19 29, and that death occurred, on the date stated above, at 6.00 P m.

The CAUSE OF DEATH* was as follows:

Endocarditis & Nephritis

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? —

(Signed) M. Casper, M. D.

, 19 (Address) 1063 Mott Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Zion Cemetery

DATE OF BURIAL: June 16, 19 29

20 UNDERTAKER: Mrs. Katie R. Williams

ADDRESS 3224 Belmont Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E46876

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E46876

90 E46876

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital ST. 12-50 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ewald G. Blanke

(a) RESIDENCE NO. 3231 St. Paul St ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. 0 mos. 0 ds. How long in U. S., if foreign birth 32 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary K. Blanke

6 DATE OF BIRTH (month, day, and year) Aug-31-1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	48	9	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Architect

(b) General nature of industry, business, or establishment in which employed (or employer) " "

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) unknown Germany

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) unknown (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) unknown (State or country) Germany

14 Informant Mrs Mary K. Blanke (wife)

(Address) 3231 St Paul St

15 Filed JUN 16 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13, 1929.

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1929, to June 13, 1929, that I last saw him alive on June 13, 1929 and that death occurred, on the date stated above, at 12:50 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Rheumatic cardio-vascular disease.

(duration) 4 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Acute Rheumatic fever 30 yrs ago.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical tests

(Signed) Bryan U. Roberts, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	June 17, 1929

20 UNDERTAKER Stewart & Co ADDRESS Balto.

OF DEATH in plain terms, so that it may be properly classified. EARLY STATEMENT OF OCCUPATION IS important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 46877

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46877

CERTIFICATE OF DEATH

1-PLACE OF DEATH Franklin Square Hospital 117

CITY OF BALTIMORE: (No. 25-73 ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James E Barker

(a) RESIDENCE No. 2409 Brohawn Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 9, 1923

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	-	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER James F. Barker

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Lucetta Burkhart

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Mr. James F. Barker (Address) 2409 Brohawn Ave

15 Filed JUN 16 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 1929

17 I HEREBY CERTIFY, That I attended deceased from 6-9 .1929. to 6-14 .1929. that I last saw him alive on June 14 .1929. and that death occurred, on the date stated above, at 6.25 P. m.

The CAUSE OF DEATH* was as follows:

Gangrenous Appendicitis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 6-3-29

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) C. W. Beale, M. D.

6/14 29 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL June 17 1929

20 UNDERTAKER Joseph B Cook — ADDRESS 1003 West Baltimore St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46878

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001 46878

E 46878

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 520-1/2 Poplar Grove ST. 16-69 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Virginia L. Carter

(a) RESIDENCE NO. 520-1/2 Poplar Grove ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of George W. Carter

6 DATE OF BIRTH (month, day, and year) March 30, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	65	2	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Howard County,
(State or country) Maryland

PARENTS

10 NAME OF FATHER E. A. Harmon

11 BIRTHPLACE OF FATHER (city or town) A. A. County
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Eleanora Shipley

13 BIRTHPLACE OF MOTHER (city or town) Howard County
(State or country) Maryland

14 Informant Mrs. Elener Devilbiss
(Address) 520-1/2 Poplar Grove St.

15 Filed JUN 16 1929 WILLIAM H. JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1923, to June 13, 1929, that I last saw her alive on June 13, 1929 and that death occurred, on the date stated above, at 10.24 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) — yrs. — mos. 15 ds.

CONTRIBUTORY (Secondary) Paralysis agitans

(duration) 18 yrs. — mos. — ds.

18 Where was disease contracted If not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Charles P. Clark, M. D.

6/16, 1929 (Address) 3214 Piedmont Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery

DATE OF BURIAL June 17, 1929

20 UNDERTAKER Joseph B Cook

ADDRESS 1003 West Baltimore St.

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46879 ✓ E 46879

E 46879

CERTIFICATE OF DEATH

X 202

1-PLACE OF DEATH

City of Baltimore: (No. St. Joseph Hospital St. 9-17 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME A. Scott Robinson, Jr.

(a) RESIDENCE NO. Fallston, Md. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 20/1914

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	15	3	27 26.	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer) Belair High School
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Harford Co., Md.

PARENTS

10 NAME OF FATHER A. Scott Robinson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Harford Co., Md.

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto., Md.

14 Informant Chas. E. Gross
(Address) Fallston, Md.

15 FILED ... 19.. C. HAMPSON JONES, M. D. Registrar

JUN 16 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10/29

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Cardiac Decompensation- Left congenital diaphramagic hernia

(duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary) History of accidentally being struck while playing hand ball (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? 2 weeks ago.

Did an operation precede death? no Date of

Was there an autopsy? yes at St. Joseph Hosp.

What test confirmed diagnosis?

(Signed) J. S. Carr, M. D.

6/10/29 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Union Chapel Cem.	June 19, 1929
20 UNDERTAKER Homekeepers Goods	ADDRESS Denson Inc

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46880

CERTIFICATE OF DEATH.

X 57

E 46880

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. U.S Marine Hospital) 12-51 (WARD)

2-FULL NAME William Fletcher

(a) RESIDENCE No. 2015 14th st S.E. Washington, D.C. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence Fletcher

6 DATE OF BIRTH (month, day, and year) Aug. 31, 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	48	9	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundry man

(b) General nature of industry, business, or establishment in which employed (or employer) 041

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) ~~Frederick H. Fletcher~~ Washington, D.C

PARENTS

10 NAME OF FATHER Frederick H.

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER Katherine Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Carlisle, Pa.

14 Informant Clinical records (Address) Marine Hospital

15 Filed ..., 19... C. HAMPSON JONES, M. D. Registrar

CN 161323

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15 1929

17

I HEREBY CERTIFY, That I attended deceased from June 10, 1929, to June 15, 1929, that I last saw him alive on June 15, 1929, and that death occurred, on the date stated above, at 2:15 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Erysipelas of left leg

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? NO Date of —

Was there an autopsy? NO

What test confirmed diagnosis? Clinical + Autopsy + Laboratory

(Signed) Ralph L Porter M.D.

(Address) U.S. Marine Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Washington D.C — DATE OF BURIAL June 16 1929

20 UNDERTAKER John Ulbrich — ADDRESS 2008 Orleans

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH as plainly as they would if writing a prescription. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46881

E 46881

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Sinai Hospital

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 6/16/29 ST., 1-13 WARD)

2-FULL NAME Louis B. H. Smith

(a) RESIDENCE NO. Frederick Md. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 22 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): June 27. 1884

7 AGE — Years: 44 — Months: 11 — Days: 18 — If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Warren T. Smith

(Address) Frederick Md

19 .....

C. HAMILTON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/16 1929.

17

I HEREBY CERTIFY, That I attended deceased from 5/24 .1929. to 6/16/ .1929

that I last saw him alive on 6/16/29 .19 .

and that death occurred, on the date stated above, at 7 AM m.

The CAUSE OF DEATH* was as follows:

Malaria (therapy)

Broncho pneumonia

Cardiac failure

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Central N. S. Syphilis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) By Cohen, M. D.

.19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Frederick Md

DATE OF BURIAL: June 17 1929

20 UNDERTAKER: Joseph H. Cook

ADDRESS: 1003 N. Gilmor St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46882 — 1—PLACE OF DEATH — REGISTERED NO. E 46882

CITY OF BALTIMORE: (No. 932 North Durham ST., 7-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Hostunech

(a) RESIDENCE NO. 932 North Durham ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male.	White	Married.

a If married, widowed, or divorced HUSBAND of (or) WIFE of Angela Hostunech

6 DATE OF BIRTH (month, day, and year) Feb 14. 1878

7 AGE	Years	Months	Days	If LESS than 1 day.... hrs. or.... min.
	51	5 4	2.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter 015

(b) General nature of industry, business, or establishment in which employed (or employer) not known

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Frank Hostunech

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Angela Hostunech
(Address) 932 N. Durham St.

15 [illegible] J. HAMPSON JONES, M. D.
Registrar

JN 17 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16. 29

17 I HEREBY CERTIFY, That I attended deceased from May 21, 1929 to June 16 1929

that I last saw him alive on June 16 1929

and that death occurred, on the date stated above, at 10 30 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Arrhythmia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J. Hyams M. D.

(Address) 801 N. Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oak Hill Cemetery	June 18 1929
20 UNDERTAKER	ADDRESS
August Rasek	2406 Ashland Ave.

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46883 — CERTIFICATE OF DEATH — E 46883

REGISTERED NO.

1—PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Lombard & Greene ST. 4-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jay Myers

(a) RESIDENCE NO. Greencastle Pa. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 18 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6 DATE OF BIRTH (month, day, and year) 1925

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
4				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dont Know

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dont Know

14 Informant Charles Starkey

(Address) Lombard & Wallbrook

15 Filed JUN 17 1929 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-16-29

17 I HEREBY CERTIFY, That I attended deceased from 5-28, 1929, to 6-16, 1929

that I last saw h[illegible] alive on 6-16, 1929

and that death occurred, on the date stated above, at 2 10 p.m.

The CAUSE OF DEATH* was as follows:

Cerebellar tumor (endothelioma)

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease rontracted if not at place of death? unknown

Did an operation precede death? Date of

Was there an autopsy? yes

What test ronfirmed diagnosis? Clinical & autopsy

(Signed) Henry Vincent Davis, M. D.

6/16, 1929 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suiridal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green castle Pa	6/18 1929
20 UNDERTAKER W W Stevens	ADDRESS 1514 Walnut St

IMPORTANT. See instructions on back of certificates. It is the duty of the parent, or other person having charge of a child, to report the death of such child to the Registrar of Births and Deaths, and to secure a burial permit before the body is removed from the premises. Each statement of OCCUPATION may be important.

Spec.—2-29-28—L. F. S.—50) Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46884

CERTIFICATE OF DEATH

E 46884

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1609 Lorman St ST. 15-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rebecca Wright

(a) RESIDENCE NO. 1609 Lorman ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	B	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 0'0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Isaac Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Fabey Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Robt Young
(Address) 1609 Lorman St

15 Filed JUN 17 1929 HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-15-29.

17 I HEREBY CERTIFY, That I attended deceased from 5/28, 1929, to June 14, 1929, that I last saw h alive on June 14, 1929 and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Ch Myocarditis

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No What test confirmed diagnosis? Physical

(Signed) A. G. Hornstein, M. D.

6/16, 1929 (Address) 733 Argyle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemetery	6/17 1929
UNDERTAKER D J W Lentz	ADDRESS 307 E 33rd St

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46885

E 46885

CERTIFICATE OF DEATH

74-001

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hosp. 18-24 Ward)

2-FULL NAME Harry Wyche

(a) RESIDENCE NO. 436 N. Fremont St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 Color or Race: Col | 5 Single, Married, Widowed or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) 1904

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	35	25		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town): Va
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant: Gertrude Clark
(Address) 436 N. Fremont

15 Filed C. HAMPSON JONES, M. D. Registrar

By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10, 1929

I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said Autopsy & Inquest (Inquest, autopsy or inquiry) and that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 3 hours

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 436 N. Fremont

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) [illegible] M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: National Cem. | DATE OF BURIAL: 6/11/29

20 UNDERTAKER: Daniel Easton | ADDRESS: 916 Pine

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

N 171929

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46886

CERTIFICATE OF DEATH

E 46886

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Hopkins Hospital St., 7-9 Ward)

2-FULL NAME Wm. Eugene Curtis

(a) RESIDENCE NO. Sparks, Md. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 5/1925

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	3	11	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Maryland

PARENTS

10 NAME OF FATHER Thos. Curtis

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Bessie Willis

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Landon Brooks
(Address) Sparks, Md.

Filed 6/17/29 19 HAMILTON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16/29

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:
Septicemia- Accidently fell and hurt knee (infection)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease enntracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes at Hopkins

What test confirmed diagnosis?

(Signed) J S Hatcher, M. D.

(Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Falls Road Chapel, Butler, Md. DATE OF BURIAL June 18 1929

20 UNDERTAKER Wm. C. Burkhart Son ADDRESS Sparks, Md.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46887

CERTIFICATE OF DEATH.

X 74-001

E 46887
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Franklin Square Hospital ST., WARD)

2-FULL NAME Mr albert Fish

(a) RESIDENCE NO. 5-5 Monroe Place ST., Bloomfield, N. J. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	white	widowed

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Ruth Fish

6 DATE OF BIRTH (month, day, and year) June 10 - 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or ... min.
	57		5.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Contractor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cleveland Ohio

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Albert W. Fish Jr
(Address) 55 Monroe St

15 C. HARRISON JONES, M.D. Registrar

UN 177929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15 1929

17

I HEREBY CERTIFY, That I attended deceased from June 3, 1929, to June 15, 1929, that I last saw him alive on June 15, 1929, and that death occurred, on the date stated above, at 10:20 P m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis with hypertension
Cerebral haemorrhage with
right hemiplegia (12 days
duration) (duration) yrs. mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Arthur Barbieri, M. D.

6/15 1929 (Address) Franklin Sq. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Newark N. Jersey — DATE OF BURIAL 6/17 1929

20 UNDERTAKER Wm Cook — ADDRESS 1211 Park

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

46888

E 46888

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Joseph Hospital St. 25-75 (Ward) 194

2-FULL NAME Charles Keil

(a) RESIDENCE NO. 3015 S. 6th St. Brooklyn Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1½ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Augusta Keil

6 DATE OF BIRTH (month, day, and year) Dec 18/1876

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	52	5	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Balto. Transfer Co

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Augusta Keil

(Address) 3015 S. 6th St

15 Filed [illegible] 19 C. HARRISON JONES M. D. Registrar

By [illegible]

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heat Prostration

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature], M. D.

6/17/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery

DATE OF BURIAL 6/18 19 29

20 UNDERTAKER William Cook

ADDRESS 12 175 [illegible]

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

JUN 17 1929

Spec.—1-10-21—M&T—1500 Blks.

46889

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

66 E 46889

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4203 Valley View Ave., ST., 26-41 WARD)

2-FULL NAME Edgar Ignatius Fetsch

(a) RESIDENCE No. 4203 Valley View Ave., Raspeburg ST., 26th WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Nellie R. Fetsch

6 DATE OF BIRTH (month, day, and year) Oct. 23, 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
42	43	4	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Employee of Secret Service, U.S.A.

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John M. Fetsch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Emma Applegarth

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Nellie R. Fetsch

(Address) 4203 Valley View Ave.

15 Filed JUN 17 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15, 19 29

17

I HEREBY CERTIFY, That I attended deceased from May 18, 19 29, to June 15th, 19 29, that I last saw h in alive on June 14th, 19 29, and that death occurred, on the date stated above, at 2 A.M. m.

The CAUSE OF DEATH* was as follows:

Chronic Alcoholism

Several years.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) A. L. Wilkinson, M. D.

6/15, 1929 (Address) A. L. Wilkinson,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL 6/17 19 29

UNDERTAKER Grecian Cook — ADDRESS 12/18 St Paul

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46890

CERTIFICATE OF DEATH

VE 46890

1—PLACE OF DEATH

BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE: (No. [redacted] ST., 73-31 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John W. Hooper

(a) RESIDENCE NO. 1021 So Chapel ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Geo

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Catherine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Richds

(Address) [redacted] BALTIMORE CITY HOSPITALS

15 Filed ....., 19.... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-14-29

17

I HEREBY CERTIFY, That I attended deceased from 10-14, 1926, to 6-14, 1929

that I last saw h[illegible] alive on 6-14, 1929

and that death occurred, on the date stated above, at 10:05 P.M.

The CAUSE OF DEATH* was as follows:

Central Nervous System Syphilis — Tabes Dorsalis

CONTRIBUTORY (Secondary) Blindness 3 yrs. mos. ds. — meningitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) [redacted], M. D.

, 19 (Address) [redacted] BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	June 18 1929
20 UNDERTAKER John H. Trader	ADDRESS 1027 Edmondson Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

188-103

E 46891

CERTIFICATE OF DEATH

E 46891

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hospital 1626 St., Ward)

2-FULL NAME Clara Lorrtta Brooks

(a) RESIDENCE NO. 1211 Harlem St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. 5 mos. 1 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? [illegible] mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F	C	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Jan 14-1920

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	9	5	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer) do
(c) Name of employer School

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Wm F. Brooks

11 BIRTHPLACE OF FATHER (city or town) Charlotte
(State or country) Co - Va

12 MAIDEN NAME OF MOTHER Eva Darr

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Eva Darr
(Address) 1211 Harlem

15 Filed [illegible] Registrar

JAN 17 '29

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Traumatic Fract Skull - accom while on roller skates struck auto driven by Robt Butts in front of 629 Carey and that her death was due to her own negligence and exonerate Robt Butts

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) auto accident

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? ..... Date of

Was there an autopsy? ..... What test confirmed diagnosis? J. J. Franz

(Signed) H. H. Mc Elderry, M. D.

6/17, 1929 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	June 19 29
20 UNDERTAKER	ADDRESS
Sam W. Chase & Son	1400 Madison

C. HAMPSON JONES, M. D.

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 46892

CERTIFICATE OF DEATH

E 46892

1-PLACE OF DEATH

City of Baltimore: (No. Hopkins Hospital St., 8-17 Ward)

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Edgar E. Foard

(a) RESIDENCE NO. 2050 E. Hoffman St., Ward _____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
male	white	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 15/1929

7 AGE Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	1	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) _____
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Edgar J. Foard

11 BIRTHPLACE OF FATHER (city or town) _____
(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Violet Gettman

13 BIRTHPLACE OF MOTHER (city or town) _____
(State or country) Balto., Md.

14 Informant Edgar J. Foard
(Address) 2050 E. Hoffman St

15 Filed JUN 17 1929, 19__ C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (Primary)

_____ (duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary) _____

_____ (duration) ..yrs. ..mos. ..ds.

18 Where was disease contracted If not at place of death? _____

Did an operation precede death? no Date of _____

Was there an autopsy? no

What test confirmed diagnosis? _____

(Signed) J. A. Kolmer, M. D.

6/17/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Carmel Cemetery	6/17 1929
20 UNDERTAKER George J. Ruth	ADDRESS 1735 Harford Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

Jost Fink

E 46893

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49

E 46893

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Balto. City Hosp. ST. 6-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jos Fink

(a) RESIDENCE NO. 1600 E. Fayette ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Marie Fink

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Fink

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

11 Informant Hosp. Record.

(Address)

Filed JUN 17 1929 19 HARRISON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/15/29

17 I HEREBY CERTIFY, That I attended deceased from 5/22, 1929, to 6/15, 1929, that I last saw h/ alive on 6/15, 1929 and that death occurred, on the date stated above, at 9:50 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of right side of neck - Primary

(duration) Unknown mos. ds.

CONTRIBUTORY (Secondary) Secondary hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. A. Crumpton, M. D.

6/16, 1929 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore	Jun 18 19 29
20 UNDERTAKER	ADDRESS
Louis Heeman	925 E Broad

IMPORTANT. See instructions on back of certificates. DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46894

CERTIFICATE OF DEATH

129 E 46894

1—PLACE OF DEATH

REGISTERED NO. 12-50

CITY OF BALTIMORE: (No.) 337 E 22nd ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edna Rowe Duvall

(a) RESIDENCE NO. 337 E. 22nd ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

a If married, widowed, or divorced HUSBAND of (or) WIFE of: David Herbert Duvall

6 DATE OF BIRTH (month, day, and year): Sept. 14 1881

7 AGE — Years: 47 — Months: 9 — Days: 1 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 1037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): A. A. Co. Md.

PARENTS

10 NAME OF FATHER: Dr. Caleb B. White

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Eleanor V. Burnett

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md.

14 Informant: Mr. David Herbert Duvall

(Address) 337 E. 22nd St.

15 Filed 1929 C. HAMPSON JONES, M. D. Registrar

JUL 17 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 15 1929

17

I HEREBY CERTIFY, That I attended deceased from June 5, 1929, to June 15, 1929,

that I last saw h[illegible] alive on June 15, 1929

and that death occurred, on the date stated above, at 9.55 a.m.

The CAUSE OF DEATH* was as follows:

Duration of illness

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic nephritis & hypertension

(duration) 12 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) John L. Sundman, M. D.

, 19 (Address) 1710 N. Charles St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cemetery	June 19 29
20 UNDERTAKER: C. O. Pickier Sons	ADDRESS: Nord & Pa

important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 46895

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

E 46895

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Home for Incurables

CITY OF BALTIMORE: (No. 40th & Cedar Ave. ST. 12-50 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary D. Boyden

(a) RESIDENCE NO. 14 E. 33rd St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George A. Boyden

6 DATE OF BIRTH (month, day, and year) Oct 5, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	56	8	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New York City

PARENTS

10 NAME OF FATHER Alonza Decker

11 BIRTHPLACE OF FATHER (city or town) Hillon (State or country) New York

12 MAIDEN NAME OF MOTHER Roseamie T. Smith

13 BIRTHPLACE OF MOTHER (city or town) New York (State or country) New York

14 Informant Home Records (Address)

15 Filed [illegible] C. HARRISON JONES, M. D. Registrar

JN 17 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15 1929

17 I HEREBY CERTIFY, That I attended deceased from October 14 1928 to June 14 1929.

that I last saw her alive on June 14 1929,

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Infectious Arthritis

(duration) 6 yrs. — mos — ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia (duration) yrs. 1 mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Phys. Physical Exam

(Signed) Phys. Mayo, M. D.

6/16 1929 (Address) Medical Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem

DATE OF BURIAL 6/19 1929

20 UNDERTAKER [illegible]

ADDRESS [illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 46896

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 46896

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 125 N Dallas St. 6-9 WARD)

2-FULL NAME Robert Powell

(a) RESIDENCE NO. 125 N Dallas ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1893

7 AGE — Years: 36 — Months — Days — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer gen'l

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant: Mrs Emma Collins

(Address) 125 N Dallas St

15 Filed JUN 17 1925 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 13 1925

17

I HEREBY CERTIFY, That I attended deceased from May 30, 1925 to June 13, 1925.

that I last saw h alive on June 12, 1925

and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Endocardial hyperplasia

(duration) yrs 2 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Physical

(Signed) [illegible] M. D.

6-17, 1925 (Address) 508 [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem.

DATE OF BURIAL: June 17 1925

20 UNDERTAKER: Mrs J. G. Locke

ADDRESS: 1302 Jeff

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46897

1-PLACE OF DEATH

City of Baltimore: (No. Mercy Hospital. St. 5-8 Ward)

2-FULL NAME Theadore A.Thomas.(O)

(a) RESIDENCE NO. 351 Forrest St. St., Ward
(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. ---- mos. ---- ds. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

194

E 46897

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	57	----------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Vieginia
(State or country)

PARENTS

10 NAME OF FATHER Hirah Thomas.(O)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Millie Ely.(O)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia.

14 Informant Wesley Thomas.(O) brother.
(Address) Hobson, Va.

15 Filed JUN 17 1929 19 HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Heat Prostration.
Acute dilatation of the Heart.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What tests confirmed diagnosis? Inquiry

(Signed) Otto Kernhardt, M. D.

6/17, 1929 (Address) 101 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hobson Va. June	18 19 29

20 UNDERTAKER Chas. N. Johnson ADDRESS 416 N. Carlton St.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 46898

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46898

CERTIFICATE OF DEATH.

90

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 14-20 WARD)

2-FULL NAME Mildred Wallace

(a) RESIDENCE No. 1814 Madison ST., use WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct. 25, 1920

7 AGE — Years: 8 — Months: 7 — Days: 20. — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md —

PARENTS

10 NAME OF FATHER Richard Wallace

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md —

12 MAIDEN NAME OF MOTHER Ida Cathy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md —

14 Informant Friends —

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUN 17 1929 19 C. HAMPSON JONES, M. D. Nr. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15 1929

17 I HEREBY CERTIFY, That I attended deceased from Apr 5 1929 to June 15 1929 that I last saw her alive on June 15 1929 and that death occurred, on the date stated above, at 6 45 a m.

The CAUSE OF DEATH* was as follows:

Rheumatic heart disease. Pericarditis, endocarditis, myocarditis mitral insufficiency & stenosis

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? yes

What test confirmed diagnosis? "

(Signed) S. C. Goodwin M. D.

June 17 1929 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Calvary — DATE OF BURIAL: June 17, 29

20 UNDERTAKER: Mrs. R. G. Elliott — ADDRESS: 1713 Ashland

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46899

CERTIFICATE OF DEATH

24-981

E 46899

1—PLACE OF DEATH

REGISTERED NO. 13-59

CITY OF BALTIMORE: (No. 816 Brookes Lane ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Caroline Colm

(a) RESIDENCE NO. 816 Brookes Lane ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Moses Colm

6 DATE OF BIRTH (month, day, and year): Nov 23 1837

7 AGE: Years 91 | Months 6 | Days 24 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Mordicai Hecht

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Betta Gutman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Mary Stern

(Address) 816 Brookes Lane

15 Filed JUN 17 1929, 19 HERSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 16/1929

17 I HEREBY CERTIFY, That I attended deceased from June 12, 1929, to June 16, 1929, that I last saw h— alive on June 16 1929 5 P.M. and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

arteriosclerosis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary): cerebral hemorrhage

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? -

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) J Frederick Lentz, M. D.

6-17, 1929 (Address) Temple Gardens

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lot

DATE OF BURIAL: June 19th 1929

20 UNDERTAKER: Isadore Levy

ADDRESS: 1184 W. Baltimore

Hurd Sondheim

C N 17929

OF DEATH in plain terms, so that it may be properly classified. Have statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

~~E—46850~~ E46900

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-00

~~E—46850~~ E46900

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH University Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1 ST., 1625 (WARD)

2—FULL NAME Melbourne Mac Farlane

(a) RESIDENCE NO. 717 W. Payson ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

a If married, widowed, or divorced HUSBAND of (or WIFE of) Hazel C. Dittel

6 DATE OF BIRTH (month, day, and year) Aug 8th 1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26	3	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Miller Co. N.Y.

9 BIRTHPLACE (city or town) (State or country) Philadelphia Penna

PARENTS

10 NAME OF FATHER Wm B. Macfarland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Emma Wray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Phila. Penna

14 Informant Emma C. Macfarland

(Address) 717 W. Payson St.

15 Filed JUN 17 1929 SAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15, 1929

17

I HEREBY CERTIFY, That I attended deceased from June 10, 1929, to June 15, 1929, that I last saw h[illegible] alive on June 15, 1929 and that death occurred, on the date stated above, at 1.05 a.m.

The CAUSE OF DEATH* was as follows:

Cellulitis, left foot

CONTRIBUTORY (Secondary) Acute lymphangitis, left [illegible] (duration) yrs. mos. 7 ds.

Sepsis, general [illegible] (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Hr

Did an operation precede death? Yes Date of June 8th 1929

Was there an autopsy? [illegible]

What test confirmed diagnosis? Clinical [illegible]

(Signed) G. K. Finlay M. D.

6/16, 1929 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Cemetery	June 17, 1929

20 UNDERTAKER H. B. Hufford ADDRESS 1850 W. Baltimore St

IMPORTANT—Fill in plain terms, so that it may be of property classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E [redacted] E [redacted]

E 46901 CERTIFICATE OF DEATH 90 E 46901

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 619 S. Oldham ST. 6-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME MINNIE E. LANG

(a) RESIDENCE NO. 619 S. Oldham ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6 DATE OF BIRTH (month, day, and year) October 6,1892

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	36	8	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home 037

(b) General nature of industry, business, or establishment in which employed (or employer) "

(c) Name of employer "

9 BIRTHPLACE (city or town) (State or country) Michigan

PARENTS

10 NAME OF FATHER Henry Matson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Finland

12 MAIDEN NAME OF MOTHER Mary Jacobson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Finland

11 Informant Mr. Arthur Lang (Husband)

(Address) 619 S. Oldham St.

15 Filed [illegible] 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 10th, 1929 to June 14th, 1929

that I last saw her alive on June 13, 1929

and that death occurred, on the date stated above, at 11.10 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Degeneration, Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Dilatation of Heart 1 hr.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Morris J. Schmidt M. D.

19 (Address) 1511 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery — DATE OF BURIAL: June 17, 1929

20 UNDERTAKER: Henry Sander & Sons Inc — ADDRESS: BALTIMORE ST. & BROADWAY.

IMPORTANT. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E [redacted] E 46902

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46902 E [redacted] E 46902

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 215 Rock ST. 18-26 (WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elenora Reese

(a) RESIDENCE No. 215 Rock. ST., ... WARD .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 8 mos. 6 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Fem'l

4 COLOR OR RACE Col'd

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Wilson Reese

6 DATE OF BIRTH (month, day, and year) 1877-Oct 8

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	8	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md. (State or country)

PARENTS

10 NAME OF FATHER Wm L. Sorrell

11 BIRTHPLACE OF FATHER (city or town) Va. (State or country)

12 MAIDEN NAME OF MOTHER Mary E. Snowden

13 BIRTHPLACE OF MOTHER (city or town) Howard Co (State or country) Md

14 Informant Isabella Sorrelle (Address) 119 N. Fulton Ave

15 Filed JUN 17 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 1929

17 I HEREBY CERTIFY, That I attended deceased from May 23 1929, to June 14 1929.

that I last saw h[illegible] alive on June 13 1929

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) F. Kendrick, M. D.

June 14 1929 (Address) Walbrook Division

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery — DATE OF BURIAL: June 17, 1929

20 UNDERTAKER: Mrs Kate R. Williams — ADDRESS: 322 [illegible]

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E [redacted] E 46903

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46903

CERTIFICATE OF DEATH

74-001 E 46903

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 624 S Linwood Ave WARD)

2—FULL NAME Robert W Brownley

(a) RESIDENCE NO. 624 S Linwood Ave WARD
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ida M. Brownley

6 DATE OF BIRTH (month, day, and year): Sept 3 1870

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	58	9	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Labor

(b) General nature of industry, business, or establishment in which employed (or employer): Fertilizer Works

(c) Name of employer: American Agricultural Chem Co

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Larkin B. Brownley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Melissa Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ind.

14 Informant: Alonzo Jones

(Address) 624 S Linwood Ave

15 Filed JUN 17 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 16 1929

17 I HEREBY CERTIFY, That I attended deceased from June 14, 1929, to June 15, 1929, that I last saw h... alive on June 15, 1929, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 1 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) C. J. Tony, M. D.

6/16, 1929 (Address) 2711 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel	June 18 1929

20 UNDERTAKER: M. W. E. Diffendal Inc ADDRESS 371 Cam...

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 46904

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46904

E [redacted]

CERTIFICATE OF DEATH

31

E [redacted]

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1850 N. Collington ST., 9th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Davis

(a) RESIDENCE NO. 1850 N. Collington ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Davis

6 DATE OF BIRTH (month, day, and year): April 15-1895

7 AGE — Years: 34 — Months: 2. — Days: 1 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework.

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer: at Home.

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Joseph Trawinski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Stanly Rzeskowiak

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland.

14 Informant: Joseph Davis

(Address): 1850 N. Collington Ave

Filed JUN 17 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 16-1929

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1929 to June 16, 1929 that I last saw h[illegible] alive on June 12, 1929 and that death occurred, on the date stated above, at 330 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) Don't Know yrs. mos. ds.

CONTRIBUTORY (Secondary) Pregnancy & Puerperium

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) J. Edward Norris, M. D.

6.17. 1929 (Address) 107 East west St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Rosary — DATE OF BURIAL: June 18 1929

20 UNDERTAKER: F. W. Ozazewski — ADDRESS: 1930 Eastern Ave

IMPORTANT. See instructions on back of certificates. OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

118-001

E 46905

CERTIFICATE OF DEATH

E 46905

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. St Josephs Hospital 6-10 WARD)

2—FULL NAME Anna Spec

(a) RESIDENCE NO. 1427 Jefferson ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frank Spec

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	71			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Joseph Schrotal

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Frank Spec

(Address) 1427 Jefferson St

Filed JUN 17 1929 SHAMER JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/15/29

17 I HEREBY CERTIFY, That I attended deceased from 6/3/29, 19..., to 6/15/29, 19..., that I last saw h.. alive on 6/15/29, 19..., and that death occurred, on the date stated above, at 2:20 P. m.

The CAUSE OF DEATH* was as follows:

Strangulated umbilical hernia

(duration) yrs. mos. 12 ds.

CONTRIBUTORY (Secondary) cardiac decompensation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 6/14/29

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. C. Zeman, M. D.

, 19 (Address) St Josephs

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	June 18 19
20 UNDERTAKER	ADDRESS
Frank Croxton	1908 Eutaw Pl

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46906

CERTIFICATE OF DEATH

38

E 46906

1—PLACE OF DEATH Bello City Hospts. REGISTERED NO.

CITY OF BALTIMORE: (No. Balto Md. ST. 18-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Good

(a) RESIDENCE NO. 117 W. Lexington St ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Blk	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35 2			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer Odd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. Carolina

PARENTS

10 NAME OF FATHER Landus Good

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Carolina

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Carolina

14 Informant Bello City Hospt.
(Address) Balto Md.

15 1929 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-14-29

17 I HEREBY CERTIFY, That I attended deceased from 6-12, 1929 to 6-14, 1929

that I last saw him alive on 6-13, 1929

and that death occurred, on the date stated above, at 7.30 A m.

The CAUSE OF DEATH* was as follows:

General Paralysis of Insane

Luetic Infection (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Henry Feldmann M. D.

6/14, 1929 (Address) Bello City Hospt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

Acute Lobar Pneumonia

19 CREMATION OR RE- Asbury Cemetery DATE OF BURIAL 11-5-29

20 UNDERTAKER Robert E Williams ADDRESS 1515 N. Eden

Spec.—2-29-28—L. F. S.—500 Blks.

important. See instructions on back of certificates.

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46907 — 38 — E 46907

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. Balto. City Hosp'ls, ST., [illegible] WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Percy Murdock

(a) RESIDENCE NO. 200 S Caroline ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Blk.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Balto City Hosp'ls
(Address) Balto Md.

15 Filed JUN 17 1929 19 HAMSON JONES, M. D. Registrar

THE MORGUE

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-13-29

17 I HEREBY CERTIFY, That I attended deceased from 5-16, 1929, to 6-13, 1929

that I last saw h.l.m. alive on 5-16, 1929

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

General Paralysis (Of Insane)

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Luetic Infection

(duration) yrs. ? mos. ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical & Laboratory

(Signed) Harry Goodman, M. D.

6/13, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
UNIVERSITY OF MARYLAND	JUN 1 1929
20 UNDERTAKER	ADDRESS
Commissioner Health.	

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46908

CERTIFICATE OF DEATH.

E 46908

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 2104 Ramsay St. 20-69 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Adam Erck.

(a) RESIDENCE NO. 2104 Ramsay St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Pauline M. Erck.

6 DATE OF BIRTH (month, day, and year): August 9th. 1867

7 AGE Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
61	10	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of Indnstry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town):

(State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Anna Erck.

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Germany

14 Informant: Mrs. Pauline M. Erck.

(Address): 2104 Ramsay St.

15 Filed JUN 17 1929, 19

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1929: June 14th.

17 I HEREBY CERTIFY, That I attended deceased from June 5, 1929, to June 14, 1929, that I last saw him alive on June 14, 1929, and that death occurred, on the date stated above, at 11 1 m.

The CAUSE OF DEATH* was as follows: Erysipelas (June 5 - June 14)

Chronic Interstitial Nephritis (duration) Unknown mos. ds.

CONTRIBUTORY (Secondary) Senile Cardiac Debility (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Yes

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Robert E. Peters, M. D.

6/16/1929 (Address) 2500 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: LoudonPark Cemetery Date of Burial: June 17, 29

20 UNDERTAKER: George L. Ishmal ADDRESS: 101 Eutaw Ave.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46909

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

45 ✓

E 46909

1—PLACE OF DEATH: BALTIMORE CITY HOSPITALS — REGISTERED NO.

CITY OF BALTIMORE: (No. [redacted] ST., 19-28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Samuel Ross

(a) RESIDENCE NO. 1701 W Pratt ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 85 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed or Divorced (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Ross

6 DATE OF BIRTH (month, day, and year) Aug. 4th 1839

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	89	10	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Odd

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Robert Ross

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Matilda Ford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Records of

(Address) MD. CITY HOSPITALS

15 Filed ..., 19 ... HAMPSON JONES, M. D. Registrar

UN 1 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-15-29

17 I HEREBY CERTIFY, That I attended deceased from 5-16, 1929, to 6-15, 1929, that I last saw him alive on 6-15, 1929, and that death occurred, on the date stated above, at 5:20 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Ascending Colon

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Metastasis to Lung

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Exam

(Signed) Marvin W. McLean, M. D.

, 19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	June 19 1929
20 UNDERTAKER	ADDRESS
George L. Schwab & Son	Fredk. Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Worthington

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46910

CERTIFICATE OF DEATH

31 ✓ E 46910

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST., 1[illegible]-26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Carrie Worthington

(a) RESIDENCE NO. 1428 W. Fayette st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Chas. Worthington

6 DATE OF BIRTH (month, day, and year) [illegible] 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Simmons

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Lucy Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Hospital Records

(Address)

15 [illegible] C. HAMILTON JONES, M. D.

[illegible], 19 Registrar

JUN 17 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14, 1929

17

I HEREBY CERTIFY, That I attended deceased from April 10, 1929, to June 14, 1929,

that I last saw her alive on June 14, 1929

and that death occurred, on the date stated above, at 11:30 a.m.

The CAUSE OF DEATH* was as follows:

Lobular Pneumonia

CONTRIBUTORY (Secondary) Unknown (duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) Henry C. Smith, M. D.

6-14, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL June 17 1929

20 UNDERTAKER Joseph B. Cook

ADDRESS 1033 N. Gaith St

IF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46911

46911

CERTIFICATE OF DEATH.

40

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No.) Balt & Mad. (ST.) 10-14 (WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Catherine A. Fink

(a) RESIDENCE NO. 809 E. Eager St. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James Fink

6 DATE OF BIRTH (month, day, and year): Oct 1, 1884

7 AGE — Years: 44 — Months: 8 — Days: 15 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home work

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Charles Lowenstein

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: James Fink

(Address): 809 E Eager St

15 Filed JUN 17 1929 C. HAMPSON JONES, M. D. Registrar

by .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 16 1929

17 I HEREBY CERTIFY, That I attended deceased from June 14, 1929, to June 16, 1929, that I last saw h[illegible] alive on June 16, 1929, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Tubo Ovarian abscess, Left

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary): Acute Peritonitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of June 15/29

Was there an autopsy? No What test confirmed diagnosis? Clinical Signs

(Signed) J. E. Gardenhire M. D.

, 19 (Address) Sinai Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additinnal space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — DATE OF BURIAL: June 18 19 29

20 UNDERTAKER: Elmer W. Conklin — ADDRESS: 824 E Eager

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46912

CERTIFICATE OF DEATH.

90 E 46912

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 165 Patapsco ST. 23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen B. Copenhaver

(a) RESIDENCE NO. 165 Patapsco ST., 23 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 COLOR OR RACE: White | 5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Elis F. Copenhaver

6 DATE OF BIRTH (month, day, and year): May - 1899

7 AGE: Years 36 | Months 1 | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife 037

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Winchester Va

PARENTS

10 NAME OF FATHER: Wesley Wine

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Emma Tyden

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Winchester Va

14 Informant: Elis F. Copenhaver (Address) 165 Patapsco St.

15 Filed: JUN 17 1929 G. Hanson Jones, M. D. Registrar

UN 177929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 17 1929

17 I HEREBY CERTIFY, That I attended deceased from June 17, 1929, to June 17, 1929, that I last saw h. alive on June 17, 1929, and that death occurred, on the date stated above, at 9-30 A m.

The CAUSE OF DEATH* was as follows:

Childbirth

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Shock due to Ruptured Gestation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. B. Copenhaver M. D.

June 17, 1929 (Address) 164 W Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Winchester Va | DATE OF BURIAL: June 18, 1929

20 UNDERTAKER: C. Howard Evans | ADDRESS: 38 E. Fayette

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

226172 E 46913 X 135 E 46913

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Deigert

(a) RESIDENCE No. Putty Hill / Belair Rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 5 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug 11/73

7 AGE — Years: 55 Months: 10 Days: 5 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Plasterer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Valentine Deigert

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ger

12 MAIDEN NAME OF MOTHER: Mumme

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Record (Address) JOHNS HOPKINS HOSPITAL

15 Filed JUN 17 1929 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 16 1929

17 I HEREBY CERTIFY, That I attended deceased from June 11 1929 to June 16 1929, that I last saw h[illegible] alive on June 16 1929, and that death occurred, on the date stated above, at a m.

The CAUSE OF DEATH* was as follows:

Benign Prostatic Hypertrophy

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary): Uraemia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) [signature] M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Peters Lutheran — DATE OF BURIAL: 6/19 1929

UNDERTAKER: Chas. Fullerton & Son — ADDRESS: 2016 Orleans

Philip Herwig

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 46914 HEALTH DEPARTMENT—CITY OF BALTIMORE **E 46914**

CERTIFICATE OF DEATH. 185

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 222 W. Monument St. 11-24 Ward) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elisabeth Holden Gernand

(a) RESIDENCE. No. 222 W. Monument St., Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 79 yrs. 4 mos. 3 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Robert Henry Gernand

6 DATE OF BIRTH (month, day, and year) Feb 12. 1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer) ——

(c) Name of employer ——

9 BIRTHPLACE (city or town) (State or country) Baltimore City Maryland

PARENTS

10 NAME OF FATHER William Holden

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Martha Holtzhauer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary Gernand Keller

(Address) 222 W. Monument St

15 Filed JUN 17 1929 . 19 C. HAMPSON JONES, M. Registrar

Per ——

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18 1929

17

I HEREBY CERTIFY, That I attended deceased from June . 1924 . to June 15 . 1929.

that I last saw h[e] alive on June 15 . 1929.

and that death occurred, on the date stated above, at 11.47 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Fractured femur from accidental fall (duration) 5 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Down steps April 28-1929 at 9.22 P.M. (duration) — yrs. 1 mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys + X ray

(Signed) Chas. J. Keller . M. D.

6/17 . 1929 (Address) 222 W. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Johns Cemetery Waverly — DATE OF BURIAL June 18 1929

20 UNDERTAKER John B. Spence — ADDRESS 1325 N Caroline St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46915

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

45 E 46915

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2442 E. North Ave 8-16 REGISTERED NO.
ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Franklin Gable

(a) RESIDENCE NO. 2442 E. North Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 72 yrs. — mos. — ds. How long in U. S., if foreign birth? 72 yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept. 9 1846

7 AGE: Years 82 | Months 9 | Days 7 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Stone cutter

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Phila. Pa.

PARENTS

10 NAME OF FATHER: Wm. Gable

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Caroline Eichorn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Wm. Gable

(Address): 2773 Alameda Boulevard.

15 171929 C. HAMPSON JONES, M. D. Registrar

Fee 10 cts

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 16 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 4 1925 to June 16 1929, that I last saw him alive on June 16th 1929, and that death occurred, on the date stated above, at 3 15 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal Carcinoma
Saw this patient 11 days from Jan. 5 until death
Well advanced (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Dem- 18 months. Senile (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of

Was there an autopsy?

What lest confirmed diagnosis?

(Signed) Evangeline Cooke, M. D.

6/21, 19 29 (Address) 10 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: June 19 1929

20 UNDERTAKER: Henry Aboch Sons Inc — ADDRESS 1301 E Eager

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46916

CERTIFICATE OF DEATH

129 ✓ E 46916

1—PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2713 E. Monument ST., 7-10 WARD)

2—FULL NAME Joseph Kraus

(a) RESIDENCE NO. 2713 E Monument ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. — mos. — ds. How long in U. S., if foreign birth? 45 yrs. — mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Margaretha Kraus

6 DATE OF BIRTH (month, day, and year) June 15 1851

7 AGE — Years: 78 — Months: — Days: 1 — If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: John Kraus

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not Known

14 Informant: Mrs. Margaret B Kraus
(Address) 2713 E Monument St

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar
By .....

JN 17 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 16/29

17 I HEREBY CERTIFY, That I attended deceased from June 9 . 1929 , to June 16 . 1929 , that I last saw h in alive on June 16 . 1929 and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Cardio-vascular-renal disease.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Cardiac fracture.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Wm J Kelly , M. D.

6/7 . 1929 (Address) 701 N. Kenwood Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: June 19 1929

20 UNDERTAKER: Henry Stock Sons, Inc. — ADDRESS: 130, E Eager St

IMPORTANT. See instructions on back of certificates. Use black ink in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46917

CERTIFICATE OF DEATH.

57

E 46917

1-PLACE OF DEATH

City of BALTIMORE: (No. Church Home 2/27-56 St. Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret A. Neumann

(a) RESIDENCE NO. 310 Virginia Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced (or) WIFE of: Ignatius Neumann

6 DATE OF BIRTH (month, day, and year): March 14 1873

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	46	3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto.

(State or country): Md

PARENTS

10 NAME OF FATHER: Grenbury Baker

11 BIRTHPLACE OF FATHER (city or town): Balto

(State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Falkenhan

13 BIRTHPLACE OF MOTHER (city or town): Germany

(State or country):

14 Informant: Mr Ignatius Neumann

(Address): 310 Virginia Ave

15 Filed 1929 THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 16 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb 25, 1927, to June 16, 1929, that I last saw her alive on June 16, 1929, and that death occurred, on the date stated above, at 10 o'clock a m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

? (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Septicemia (Erythematoid Rash)

(duration) yrs. 21 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of March 17

Was there an autopsy? No Gangrene of Appendical Abscess

What test confirmed diagnosis?

(Signed) J. C. Monk M. Neumann, M. D.

June 16 1929 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Park Cemetery Date of Burial June 19, 1929

20 UNDERTAKER: Henry Koch & Sons, Inc. ADDRESS 1301 E. Eager St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 46918 ✓ E 46918

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. U.S. Marine Hospital ST., 7-4 WARD)

2-FULL NAME Thomas Henderson

(a) RESIDENCE NO. 1752 Hanover st, Baltimore ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 13 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of -

6 DATE OF BIRTH (month, day, and year) Mar. 1st 1889 ~~1889~~

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	40	2	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman - (?)

(b) General nature of industry, business, or establishment in which employed (or employer) cook & steward

(c) Name of employer Bridge Virginia

9 BIRTHPLACE (city or town) (State or country) Scotland -

PARENTS

10 NAME OF FATHER Richard Henderson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Scotland

12 MAIDEN NAME OF MOTHER Grace ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Scotland

14 Informant Hospital Records
(Address) Marine Hospital

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar
Per ORK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15th 1929

17 I HEREBY CERTIFY, That I attended deceased from May 29, 1929, to June 15, 1929, that I last saw he alive on June 15, 1929, and that death occurred, on the date stated above, at 8.30 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis pulmonary

..... (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ..... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of .....

Was there an autopsy? No Eatory

What test confirmed diagnosis? Surgical & labor

(Signed) Ralph Porter M. D.

, 19 (Address) U.S. Marine Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Marys, Hampden — DATE OF BURIAL: June 18, 1929

20 UNDERTAKER: E. Leroy Stiffler & Inc. — ADDRESS: 1256 North ave.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 46919 HEALTH DEPARTMENT—CITY OF BALTIMORE E 46919

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hope Eason

(a) RESIDENCE NO. Sunbury N-Car ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 2/24/27

7 AGE 5 Years 5½ Months 3 Days 23 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N-Car

PARENTS

10 NAME OF FATHER Luke Eason

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Elsey Alphin

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Reads — (Address) JOHNS HOPKINS HOSPITAL

Filed N 71929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17 1929

17 I HEREBY CERTIFY, That I attended deceased from June 13, 1929, to June 17, 1929, that I last saw her alive on June 17, 1929, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Brain tumor, malignant

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Removal of tumor June 17, 1929

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) J. Ridgeway Thomas M.D.

June 17 1929 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Norfolk Va — DATE OF BURIAL: 6/17/29

20 UNDERTAKER: Joseph Ahrens — ADDRESS: 221 Bway

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46920

E 46920

CERTIFICATE OF DEATH

74-29

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Hopkins Hospital St., 5-8 Ward)

2-FULL NAME Pietro Borghese

(a) RESIDENCE NO. 322 East St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? 20 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sebastinia Borghese

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	49			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tailor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Italy

PARENTS

10 NAME OF FATHER Joseph Borghese

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Italy

12 MAIDEN NAME OF MOTHER Christiana Pillotta

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Italy

14 Informant Wife
(Address) 322 East St

15 Filed 6/17/29 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. S. McCann, M. D.

6/17/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	June 19 19 29
20 UNDERTAKER	ADDRESS
Grant & Crockett Sons	1906 Eutaw

1171929

THE LAW REQUIRES, WITH UNFAILING FIRMNESS, THAT A PERMANENT RECORD, EXACT AND COMPLETE in every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46921

74-001

E 46921

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 11-1

CITY OF BALTIMORE: (No. 609 N. Clinton ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Kate Bamford.

(a) RESIDENCE NO. 609 N Clinton ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If foreign birth 30 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Samuel Bamford.

6 DATE OF BIRTH (month, day, and year) April 5 1882

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
47	2	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Wales

PARENTS

10 NAME OF FATHER Harry Jenkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Wales

12 MAIDEN NAME OF MOTHER Elizabeth Lewis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wales

14 Informant Samuel Bamford

(Address) 609 N Clinton St

15 Filed 1929 C. HAMPSON JONES, M. D. Registrar

Per RRH

N 171928

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15-29

17 I HEREBY CERTIFY, That I attended deceased from June 14, 19 29, to June 15, 19 29,

that I last saw h[illegible] alive on June 14, 19 29

and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Allen C. Beauchamp, M. D.

6-16, 19 29 (Address) 3139 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	June 18 19 29

20 UNDERTAKER Mrs C. Miller & Son

ADDRESS 2334 Jefferson St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46922

CERTIFICATE OF DEATH

129 V E 46922

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 429 N Rose ST. 6-10 WARD)

2—FULL NAME Augusta H. Haug

(a) RESIDENCE NO. 429 N Rose ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: John Haug

6 DATE OF BIRTH (month, day, and year): May 14-1875

7 AGE — Years: 54 | Months: 3 | Days: 1 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Karl Reinhart

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Anna Grau

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: John Haug
(Address): 429 N Rose St

15 [illegible], 19 29 C. HAMPSON JONES, M. D.
Registrar

N 17929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 15-1929

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1929, to June 15, 1929

that I last saw h[illegible] alive on June 15 1929

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

Contributed to by Arteriosclerosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Myocardial Insuff

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Wm. G. Leyrer, M. D.

, 19 (Address) 156 N. Milton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Trinity Cemetery — DATE OF BURIAL: June 18 19 29

20 UNDERTAKER: Chas C. Brille & Son — ADDRESS: 233 N Jeffer[illegible]

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46923

CERTIFICATE OF DEATH

45 ✓ E 46923

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. University Hosp ST. 12-5 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Florence Calvert

(a) RESIDENCE NO. 2549 Woodbrook Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. 5 mos. 13 ds. How long in U. S., if foreign birth? 55 yrs. 5 mos. 13 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married.

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Robert N Calvert, Sr

6 DATE OF BIRTH (month, day, and year): Jan 3rd 1874

7 AGE: Years 55 | Months 5 | Days 13 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer): House Work

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Isaac W Crowther

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Rachel J Wilhelm

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md.

14 Informant: Robert N Calvert
(Address) 2549 Woodbrook Ave

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

71929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 16, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 13, 1929, to June 16, 1929, that I last saw h alive on June 16, 1929 and that death occurred, on the date stated above, at 4:40 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma ?
Transverse Colon.

(duration) unknown.

CONTRIBUTORY (Secondary): Intestinal Obstruction

(duration) — yrs. — mos. 16 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of June 13, 1929

Was there an autopsy? No.

What test confirmed diagnosis? Physical Examination

(Signed) Bryan N Pfeiffer M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	June 19, 1929
20 UNDERTAKER	ADDRESS
Stewart & Co	Balto.

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46924

CERTIFICATE OF DEATH

90 E 46924

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Waldorf Hotel

City of Baltimore: (No. Charles & North Ave. St. 12-14 Ward)

2-FULL NAME Romulus Griffith Doyle.

(a) RESIDENCE NO. Waldorf Hotel Charles & North Ave. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 49 yrs. 4 mos. 0 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Febryary 15, 1880

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	49	4	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Solicitor for General
(b) General nature of industry, business, or establishment in which employed (or employer) Out door Advertising
(c) Name of employer Company.

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER James C. Doyle.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Leonard G. Doyle.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore, Md.

14 Informant Leonora G. Doyle. (mother)
(Address) 638 N. Charles St.

15 Filed ..... 19.....

N 171929 C. HAMPSON JONES, M. D. Registrar
Per .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon und from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.
Acute dilatation of the Heart.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? .....

Did an operation precede death? No. Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Steinhardt, M. D.

6/17, 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cemetery	June 18th 1929
20 UNDERTAKER	ADDRESS
Stewart & Co	108 W. Mulberry

IMPORTANT—WRITE PLAINLY WITH UNFADING INK—THIS IS A LEGAL RECORD. Every question should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 46925

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46925

CERTIFICATE OF DEATH.

66

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital ST., 11-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Cole

(a) RESIDENCE NO. 1204 Mc Culloh ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Orderly

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Friend

(Address) 919 Mc Culloh St.

15 [illegible] 19 C. HAMPSON JONES, M. D.

Registrar

N 171929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16 1929

17 I HEREBY CERTIFY, That I attended deceased from May 7, 1929, to June 16, 1929, that I last saw h/ alive on June 16, 1929, and that death occurred, on the date stated above, at 7 35 A m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Alcoholic Psychosis

(duration) yrs. 11 mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) George H. McDonald, M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL 6/18/1929

20 UNDERTAKER Mrs. George H. Holland — ADDRESS 1163 Druid Hill Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 46926

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

188-103

E 46926

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 1413 N Central St., 9-18 (Ward)

2-FULL NAME Margaret E. Hoover

(a) RESIDENCE NO. 1413 N Central St., 9 Ward

(Usual place of abode) 22 years (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo W. Hoover

6 DATE OF BIRTH (month, day, and year) August 4-1891

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
37	10	12	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) Domestic
(c) Name of employer

9 BIRTHPLACE (city or town) New York
(State or country) N Y

PARENTS

10 NAME OF FATHER Otto Seidel

11 BIRTHPLACE OF FATHER (city or town) Michigan
(State or country)

12 MAIDEN NAME OF MOTHER Celia Crowe

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Geo W. Hoover
(Address) 1413 Central Ave

15 Filed C. HAMPSON JONES, M. D. Registrar
By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-16 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Myocarditis Acc predisposed by an auto accident The woman was struck by auto driven by Benj Cluster on 6-11-29 and appeared recovered from shock — (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Death secondary to accident pt had due to secondary shock unavoidable (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Preston & Gumport

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Evidence

(Signed) J J Hamm, M. D.

6/17, 1929 (Address) 1039 N Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	6-19-1929
20 UNDERTAKER	ADDRESS
H. C. Brannegrow & Sons	1136

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A LEGAL RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificate.

N 171929

Spec.—2-29-28—L. F. S.—500 Bks.

E 46927

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001

E 46927

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1721 Aliceanna St. ST. 2-4 (WARD)

2—FULL NAME Leokadia Golembiewska

(a) RESIDENCE NO. 1721 Aliceanna St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. 21 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 19 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	1	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Antoni Jagielski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant John Golembiewski

(Address) 1721 Aliceanna St.

15 Filed ....., 19.... C. HAMPSON JONES, M. D. Registrar

171929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16 1929

17 I HEREBY CERTIFY, That I attended deceased from 6/14, 1929, to 6/16, 1929, that I last saw h.. alive on ....., 19.., and that death occurred, on the date stated above, at 3:15 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) ....yrs. ....mos. 2 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) ....yrs. ....mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. J. Krukow M. D.

6/17, 1929 (Address) 918 E. Fayette St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary June 19	19 29
20 UNDERTAKER John M. Webster	ADDRESS 101 S. Chester St

IMPORTANT. See instructions on back of certificates.

OF DEATH in plain terms, so that it may be properly examined. Exact statement of occupation very

Spec—12-23-21—E.B.R.S.—400 Bks.

E 46928 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 46928
Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 419 N. Pearl St. 14-25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Russell

(a) Residence No. 419 N. Pearl St., Ward
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. Black

5-Single, Married, Widowed or Divorced. (Write the word.) Infant

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 14 29

7-AGE. yrs. mos. 1 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED
(a) Trade, profession, or particular kind of work Infant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9-BIRTHPLACE (city or town) (State or Country), Baltimore Md.

PARENTS

10-NAME OF FATHER, Elijah Russel

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Kentucky Henderson County

12-MAIDEN NAME OF MOTHER, Nannie Bridgeford

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Wrontan, N. Carolina

14-
(Informant)
(Address)

Filed JUN 1 1929 C. HAMPSON JONES, M. D. Registrar.

Per

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 15-1929.

17- I HEREBY CERTIFY, That I attended deceased from June 14 1929 to June 15 1929 that I last saw her alive on June 15 1929 and that death occurred, on the date stated above, at 5:00 P.M.

The CAUSE OF DEATH* was as follows:

Premature Birth
(26 wks gestation)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Morris Rice M. D.
6-16, 1929 Address University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. DATE OF BURIAL. 19

20-UNDERTAKER. ADDRESS

STATE OF MARYLAND
BOARD OF HEALTH
JUN 1 1929

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 46929

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46929

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 1423 Madison Ave ST. 14-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Belle Barbour

(a) RESIDENCE No. 1423 Madison ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40+ yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Aug 22-1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	74 75	9	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Miss Fanny Barbour

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Thomas Barbour

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Anna Barbour

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Fanny Barbour

(Address) 1423 Madison

15 Filed JUN 13 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15 1929

17 I HEREBY CERTIFY, That I attended deceased from April 20, 19 29, to June 15, 19 29, that I last saw h alive on June 15, 19 29, and that death occurred, on the date stated above, at 8.15 A m.

The CAUSE OF DEATH* was as follows:

Interstitial Nephritis Chronic

(duration) yrs. 6 mos 7 ds.

CONTRIBUTORY (Secondary) Edema Lungs

(duration) 10? yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) William H Thysel, M. D.

June 15 1929 (Address) 1209 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

16 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem — DATE OF BURIAL June 18 1929

17 UNDERTAKER Samuel Hemsley — ADDRESS 578 N Bond

UN 131929

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46930

CERTIFICATE OF DEATH

90

E 46930

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1050 E. Eager St. 10-14 Ward)

2-FULL NAME Leo Hafemeister

(a) RESIDENCE NO. 1050 E. Eager St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 30/1857

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	72	4	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Gardener
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Germany

PARENTS

10 NAME OF FATHER Leo Hafemeister

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Wm. Arminger
(Address) 36 Hillcrest Ave

Filed JUN 18 1929 C. HAMPSON JONES, M. D. Registrar

By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 15/29

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Bronchial Asthma

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. L. Cullen, M. D.

6/17/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel

DATE OF BURIAL 6/18 1929

20 UNDERTAKER George J. Ruth

ADDRESS 1735 Hanford Ave

S.—WRITE PLAINLY, with unfading ink. THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46931

CERTIFICATE OF DEATH

100-001

E 46931

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 610 N. Eden St St 5-8 Ward)

2-FULL NAME Wm. Williams Jr.,

(a) RESIDENCE NO. 610 N. Eden St St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 8/28

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
	9	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Wm. Williams, Sr.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Augusta Donovan

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto., Md.

14 Informant (Address) Augusta Williams 610 N. Eden St.

15 Filed JUN 19 1929, 19 C. HAMPSON JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, Autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (Primary)

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. J. Walsh, M. D.

6/18/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL June 18 1929

20 UNDERTAKER Geo M. Fairbairn — ADDRESS 811 N. Wolfe

NOTE.—WRITE PLAINLY, WITH UNFADING INK.—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46932

CERTIFICATE OF DEATH

E 46932

REGISTERED NO. 16-002

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 839 South Dallas ST., 3rd WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Helen Helowicz

(a) RESIDENCE NO. 839 South Dallas Street ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan-31/1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		4	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER John Helowicz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Weronika Napora

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant John Helowicz

(Address) 839 S. Dallas Street

15 Date Received JUN 13 1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17, 1929.

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1929, to June 17, 1929, that I last saw her alive on June 17, 1929, and that death occurred, on the date stated above, at 9:30 a.m.

The CAUSE OF DEATH* was as follows:

Dysentery

Broncho Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Andrew Kuszyk, M. D.

6/17, 1929 (Address) 7539 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cemetery

DATE OF BURIAL June 18th 1929

20 UNDERTAKER George A. Weber

ADDRESS 705 S. Ann St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46933

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46933

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1405 Preston ST., 9 WARD) REGISTERED NO. 917

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William F. McCleary

(a) RESIDENCE NO. 1405 E. Preston ST., 9 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Evelyn J. McCleary

6 DATE OF BIRTH (month, day, and year): June 20 1860

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
64.	4	27	

8 OCCUPATION OF DEECASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Evelyn J. McCleary

(Address): 1410 E. Preston St.

15 Filed JUN 13 1929 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 17—1929.

17 I HEREBY CERTIFY, That I attended deceased from June 14 . 1929 to June 17 . 1929 .

that I last saw him alive on June 16 . 1929

and that death occurred, on the date stated above, at 2:16 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

CONTRIBUTORY (Secondary) ✓ (duration) yrs. 1 mos.

18 Where was disease contracted if not at place of death? ✓ (duration) yrs. mos. ds.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Benj. D. Hayden M. D.

6/17 . 1929. (Address) 1216 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pine Grove Cem. Co

UNDERTAKER: Unknown Undertaker

DATE OF BURIAL: June 19 1929

ADDRESS: 2015 Eastern Ave

IMPORTANT. See instructions on back of certificates. Exact statement of OCCUPATION is very

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46934

CERTIFICATE OF DEATH

74001

E 46934

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 918 N. Calhoun St., 16-22 Ward)

2-FULL NAME Theresa Thomas.

(a) RESIDENCE NO. 918 N. Calhoun St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Col

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Chas. Thomas.

6 DATE OF BIRTH (month, day and year): Sept 28-1875

7 AGE: Years 53 | Months 8 | Days 17 | If LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town): Charleston
(State or country): Md

PARENTS

10 NAME OF FATHER: Chas. Jones

11 BIRTHPLACE OF FATHER (city or town): Charleston
(State or country): Md

12 MAIDEN NAME OF MOTHER: Elenora Adams

13 BIRTHPLACE OF MOTHER (city or town): Charleston
(State or country): Md

14 Informant: Chas Thomas
(Address): 918 N. Calhoun

15 Filed ....., 19.... Per ..... Registrar

C. HAMILTON JONES, M. D.

UN 161929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 16 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest find that said deceased came to her death (Inquest, autopsy or inquiry) on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.
(Apoplexy) (duration) Sudden ds.

CONTRIBUTORY (Secondary) ..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) June 16 1929 Address) Coroner, M. D.

*State the Disease Causing Death, or in deaths frnm Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: June 20 1929

20 UNDERTAKER: Sam'l H. Chase & Son — ADDRESS: 1400 Madison

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

185

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46935 E 46935

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2915 Huntingdon Ave ST. 12-51 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sidney Ann Faulkner

(a) RESIDENCE. No. 2915 Huntingdon Ave ST. WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James S. Faulkner

6 DATE OF BIRTH (month, day, and year) Dec 9-1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER Jacob Smeltzer

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER Sallie Schaffstall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Miss Esther Faulkner (Address) 2915 Huntingdon Ave

15 Filed JUN 18 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16 19 29

17 I HEREBY CERTIFY, That I attended deceased from May 7 19 29, to June 16, 19 29.

that I last saw her alive on June 16 19 29

and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

E Faulkner

(duration) yrs. 3 mes. ds.

CONTRIBUTORY (Secondary) Fracture of neck of Femur (Left)

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L Cathcart M. D.

19 (Address) 112 W. 25th St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cem	June 18 19 29

20 UNDERTAKER Wm J Tuckerton ADDRESS N. Va

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46936

CERTIFICATE OF DEATH.

E 46936

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Johns Hopkins St. 12-50 Ward)

2-FULL NAME Virginia Cantalow

(a) RESIDENCE NO. 455 E. 23rd St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 Color or Race: C.

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 14, 1929

7 AGE — Years — Months — Days: 1

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Cleavea Cantalow

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Lincoln S. C.

12 MAIDEN NAME OF MOTHER Alice Jennings

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) S. C.

14 Informant Cleavea Cantalow

(Address) 455 E. 23rd St.

15 Filed JUN 18 1929 H. HAMILTON JONES, M. D. Registrar

16 Coroner

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 10/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Birth Injury

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) J. H. Mullen M. D.
(Coroner)

6/29/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death .....yrs. .....mos. .....ds. In the State .....yrs. .....mos. .....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Mount Calvary June 8 1929

20 UNDERTAKER Mrs. R. A. Elliott ADDRESS 1725 Eastlundon

NOTE.—WRITE PLAINLY WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-3-25—A Co.—200 Bks.

E 46937

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

66

E 46937

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) 908 Lanelly ct. (Ward) 10-14

2-FULL NAME William B. Scott

(a) RESIDENCE NO. 908 Lanelly Ct. (Ward)

(Usual place of abode)

Length of residence in city or town where death occurred yrs. Life mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 Color or Race: C.

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Lucinda Scott

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: Abt. 45 — Months — Days — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer. 0

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Washington

14 Informant: Lucinda Scott

(Address) 910 Lanelly ct.

JUN 13 1929

HAMILTON JONES, M. D.

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 14 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an.....(Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said.....(inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Toxemia. Probably acute Indigestion

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) Alcoholism

(duration) .....yrs. .....mos. .....ds.

(Signed) [illegible] M. D.

(Coroner)

6/13/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs., ...mos., ...ds. In the State ....yrs., ...mos., ...ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Lebanon Date of Burial June 15 1929

UNDERTAKER: W. P. G. Elliott ADDRESS 1715 Ashland Ave

N. B.—WRITE PLAINLY, WITH CAREFUL ATTENTION—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46938

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

162

E 46938

Registered No.

City of BALTIMORE: (No. 310 N Bruce St. 19-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy Burley

(a) Residence No. 310 N Bruce St., Ward

(Usual place of abode)

(If non resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, Black

5-Single, Married, Widowed or Divorced (Write the word.) Infant

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 14 1929

7-AGE, 2 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) 11 old

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore (State or Country), Maryland

PARENTS.

10-NAME OF FATHER, Richard Burley

11-BIRTHPLACE OF FATHER (city or town) (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Mary Butler

13-BIRTHPLACE OF MOTHER (city or town) (State or Country), Maryland

14- (Informant) Richard Burley

(Address) 310 N Bruce St

15- Filed C. HAMPSON JONES, M. D. Registrar.

JUN 18 1929

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) June 16 1929

I HEREBY CERTIFY, That I attended deceased from June 14 1929 to June 16 1929 that I last saw h[im] alive on June 15 1929 and that death occurred, on the date stated above, at 5 05 D m.

The CAUSE OF DEATH* was as follows:

Umbelical Tumor Sage (Spontaneous) from junction of Abdominal wall with Funis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Morris Reese M. D.

6/16 1929 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: Mount Auburn DATE OF BURIAL, June 18 1929

20-UNDERTAKER Joseph A Lively ADDRESS 4098 Reisterstown

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

46939

CERTIFICATE OF DEATH

E 46939
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Franklin Sq Hospital St. 19-27 Ward)

2-FULL NAME Estelle Byrne

(a) RESIDENCE NO. 1505 W. Lexington St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Col	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Henry Byrne

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	44	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) N. C

PARENTS

10 NAME OF FATHER W^m Williams

11 BIRTHPLACE OF FATHER (city or town)
(State or country) N. C

12 MAIDEN NAME OF MOTHER Nellie Jones

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) N. C.

14 Informant Ruth Morris
(Address) 1518 W. Lexington

15 Filed JUN 18 1929 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to h^r death on the day stated above.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. H. Bromley, M. D.

June 15. 1929 (Address) 3601 3rd Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Auburn	June 18 1929
20 UNDERTAKER	ADDRESS
Joseph A. Lively	399 N. Monroe St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.-7-17-26-5000. E 46940

HEALTH DEPARTMENT—CITY OF B[illegible]5 E 46940

CERTIFICATE OF DEATH

1-PLACE OF DEATH Mercy Hospital REGISTERED NO.

City of BALTIMORE: (No. 5-8 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Oscar Lowday alias Oscar Brown

(a) RESIDENCE NO. 216 Colvin St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX ~~Male~~ Female

4 Color or Race colored

5 Single, Married, Widowed, or Divorced, (write the word) single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1879

7 AGE Years 49 Months Days IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.

(State or country)

PARENTS

10 NAME OF FATHER Henry B. Lowday

11 BIRTHPLACE OF FATHER (City or town) Md.

(State or country)

12 MAIDEN NAME OF MOTHER Charlotte Brown

13 BIRTHPLACE OF MOTHER (city or town) Md.

(State or country)

14 Informant Elizabeth Hughes

(Address) 2007 East Pk.

15 Filed JUN 18 1929 16 C. HAMILTON JONES, M. D. Registrar

Per [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19 6/16/29

17 I HEREBY CERTIFY, That I attended deceased from 6/16 19 29 to 6/16 19 29

that I last saw him alive on 6/16/29 19

and that death occurred, on the date stated above, at 8 45 P. m.

The CAUSE OF DEATH* was as follows:

Acute Hemorrhagic Pancreatitis

10 hrs

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Peritonitis shock

10 hrs

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 6/16/29

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) Francis W. Eccles M. D.

19 (Address) Mercy Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ashley Cem. Date of Burial June 19 1929

20 UNDERTAKER Chas. H. Johnson ADDRESS 416 N. Carolina St.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46941 HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 46941

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital 22-35 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Matthew William Wilhelm

(a) RESIDENCE NO. 1620 E. Clement ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) aug. 1. 1899

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	29	10	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto., Md.

PARENTS

10 NAME OF FATHER adolph wilhelm

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Augusta Raisler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Wilhelm

(Address) 1620 E. Clement St.

15 Filed JUN 18 1929 C. HARRISON JONES, M. D. Per [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/15/29

17 I HEREBY CERTIFY, That I attended deceased from 6/11, 1929, to 6/15, 1929, that I last saw him alive on 6/15, 1929 and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Pathological

(Signed) Charles E. Hill, M. D.

6/15, 1929 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem.

DATE OF BURIAL: June 18 1929

UNDERTAKER: Margaret L. Flynn

ADDRESS: 1422 Light St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46942

E 46942

CERTIFICATE OF DEATH.

161-001

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hospital ST.; 15-65 WARD)

2-FULL NAME Baby Girl Vogelstein

(a) RESIDENCE No. 3106 Oakfield Ave ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. 4 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 11-1929

7 AGE — Years: — Months: — Days: 4 — If LESS than 1 day, hrs or .... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Sinai Hospital Balto Md

PARENTS

10 NAME OF FATHER: Harry Vogelstein

11 BIRTHPLACE OF FATHER (city or town) (State or country): Phila. Penn's.

12 MAIDEN NAME OF MOTHER: Frances Rose Shear

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant
(Address)

15 Filed JUN 18 1929 H. J. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 15 1929

17

I HEREBY CERTIFY, That I attended deceased from June 11, 1929, to June 15, 1929,
that I last saw her alive on June 15 10 P 1929
and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary): Ritter's Disease

(duration) ..... yrs. ..... mos. 4 ds.

18 Where was disease contracted if not at place of death? Sinai Hospital

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Autopsy

(Signed) James L. Swan M. D.

. 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL: 19

20 UNDERTAKER: ..... ADDRESS: .....

JUN 18 1929

Spec.—1-12-23—M&T—500 Bks.

E 46943

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 46943

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2163 Hollins St. 20-69 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James T. Norman

(a) RESIDENCE No. 2163 Hollins ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Josephine Norman

6 DATE OF BIRTH (month, day, and year) Aug 13 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	65	10	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Maryland

PARENTS

10 NAME OF FATHER Charles Norman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Mrs Josephine Norman

(Address) 2163 Hollins St

15 Filed JUN 13 1929 C. HARTOG JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/15 1929

17 I HEREBY CERTIFY, That I attended deceased from June 7 1927 to June 15 1929.

that I last saw him alive on June 15 1929

and that death occurred, on the date stated above, at 3.01 p. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

arteriosclerosis, Hypertension

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Heller Henning M. D.

6/16 1929 (Address) 2003 Hollins St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemetery	June 18 1929
20 UNDERTAKER Charles H Kahmer	ADDRESS 1932 Hollins

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec. -7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46944

CERTIFICATE OF DEATH

124

E 46944

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 1906 Bolton St., 14-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Isabelle M Durburow

(a) RESIDENCE NO. 1906 Bolton St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 15, 1851

7 AGE: Years 78 Months Days 2 IF LESS than 1 day.....hrs. or.....min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto

(State or country) Md.

PARENTS

10 NAME OF FATHER Howard Durburow

11 BIRTHPLACE OF FATHER (City or town) Balto

(State or country) Md

12 MAIDEN NAME OF MOTHER Sarah Ann Atkinson

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Md.

14 Informant Mrs Eugene Healy

(Address) 410 Bolton

15 Filed JUN 18 1929 H. HANSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17-29- 1929

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1929, to June 17, 1929, that I last saw h[illegible] alive on June 17, 1929, and that death occurred, on the date stated above, at 1.15 P m.

The CAUSE OF DEATH* was as follows:

Acute Suffocative Hepatitis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

June 19 1929 (Address) 1854 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cem. Date of Burial: 6/19/29

20 UNDERTAKER: George J Smith ADDRESS 153 Holliday

S B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46945

CERTIFICATE OF DEATH.

E 46945

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital 25-72 WARD)

2-FULL NAME Harry Day.

(a) RESIDENCE NO. near Ellicott City, Howard Co Md ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mrs. Harry Day

6 DATE OF BIRTH (month, day, and year): Dec 1 1871

7 AGE: Years 57; Months 6; Days 17; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stone Mason

(b) General nature of industry, business, or establishment in which employed (or employer): 075

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Richard Day

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Elizabeth Metcalf

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs Harry Day

(Address): Ellicott City RFD

15 Filed JUN 18 1929 C. HARRISON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 15 1929

17 I HEREBY CERTIFY, That I attended deceased from June 9, 1929, to June 18, 1929, that I last saw h alive on June 17, 1929, and that death occurred, on the date stated above, at 12 35 A m.

The CAUSE OF DEATH* was as follows:

Hypertensive Cardio Vascular Renal

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Alma N Herbert, M. D.

(Address) Ellicott City Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Zion Cemetery Howard Co

DATE OF BURIAL: 19

UNDERTAKER: Easton Sons

ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46946

CERTIFICATE OF DEATH.

E 46946
REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 262 Monastery Ave (ST.) (WARD)

2-FULL NAME Esther D. Kendall

(a) RESIDENCE NO. 262 Monastery ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Mattie J. Kendall

6 DATE OF BIRTH (month, day, and year): Aug 12-1860

7 AGE — Years: 68 | Months: 10 | Days: 5 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Florist
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Pennsylvania

PARENTS

10 NAME OF FATHER: James Kendall

11 BIRTHPLACE OF FATHER (city or town) (State or country): Pa

12 MAIDEN NAME OF MOTHER: Elmira Bayliss

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Lost River

14 Informant: Mrs Mattie Kendall
(Address) 262 Monastery Ave

15 Date received: JUN 18 1929 Registrar: C. HARRISON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 17 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 18, 1928 to June 17, 1929; that I last saw him alive on May 11, 1929; and that death occurred, on the date stated above, at 8.30 A. m.

The CAUSE OF DEATH* was as follows:
Myocarditis

(duration) yrs. 7 mos ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr. Lloyd Johnson M. D.
, 19 (Address) 1200 Frederick Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem — DATE OF BURIAL: June 19 1929

20 UNDERTAKER: John Ulrich — ADDRESS: 2008 Pulaski St

UN 18 1929

REMOVAL PERMIT should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Stefan Slowakiewicz

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

E 46947

CERTIFICATE OF DEATH

REGISTERED NO. E 46947

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1837 E, Lombard St. ST., 2-4 WARD)

2—FULL NAME Stefan Slowakiewicz

(a) RESIDENCE NO. 1837 E, Lombard St. ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Stefania Slowakiewicz

6 DATE OF BIRTH (month, day, and year) Nov 22. 1879

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer not employed

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Christopher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Szara

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Theodore Solowakiewicz
(Address) 224 S. Ann St.

15 Date received JUN 13 1929, 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16, 1929.

17 I HEREBY CERTIFY, That I attended deceased from June, 19 28, to June 16, 19 29 (1929)

that I last saw him alive on June 16, 19 29

and that death occurred, on the date stated above, at 6 30 P. m.

The CAUSE OF DEATH* was as follows:

Chr. Arteriosclerosis of
Chr. Hypertension —
Cerebral apoplexy —
(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral apoplexy
(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? residence

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Isaac F. Ziegler, M. D.

6/17, 1929 (Address) 1200 E. Baltimore St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary June 20. DATE OF BURIAL 1929

20 UNDERTAKER J. W. Ozazewska ADDRESS 1900 E. Baltimore St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46948

CERTIFICATE OF DEATH

90

E 46948

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO. 26-37

CITY OF BALTIMORE: (No. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Mullaney

(a) RESIDENCE NO. 310 S. Bay (is E.) ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James J. Mullaney,

6 DATE OF BIRTH (month, day, and year) ? 1861 1856.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
~~73~~	68	mmm 6 21 29		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) ?

(State or country) Md.

PARENTS

10 NAME OF FATHER Geo. Westbey ?

11 BIRTHPLACE OF FATHER (city or town) ?

(State or country) Md.

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ?

(State or country) Md.

14 Informant Records

(Address) BALTIMORE CITY HOSPITALS

15 Filed , 19 C. HAMPSON JONES, M. D.

Registrar

UN 15525 100

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-16-29

17 I HEREBY CERTIFY, That I attended deceased from 6-13, 1929, to 6-16, 1929,

that I last saw h[illegible] alive on 6-16, 1929

and that death occurred, on the date stated above, at 7.15 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis

Fibrocarditis, chronic

insufficiency

(duration) yrs. mos. 35 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical exam

(Signed) [illegible] M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cemetery	June 19 29
20 UNDERTAKER	ADDRESS
[illegible]	[illegible]

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

No. E 46949

CERTIFICATE OF DEATH.

No. E 46949

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 643 N Mulberry (ST.) 4-25 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Hall Sr.

(a) RESIDENCE No. 643 N Mulberry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah Hall

6 DATE OF BIRTH (month, day, and year): 1867

7 AGE: Years 62; Months; Days; If LESS than 1 day, hrs or... min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown.

14 Informant: Sarah Hall

(Address) 643 Mulberry St

15 Filed JUN 18 1929 19... C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 16 1929

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1929, to June 16, 1929.

that I last saw him alive on June 16, 1929

and that death occurred, on the date stated above, at 12.02 p m

The CAUSE OF DEATH* was as follows: Carcinoma of Stomach and Liver

(duration) yrs. 10 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet

DATE OF BURIAL: 6-18 1929

20 UNDERTAKER: Daniel Eaton & Co

ADDRESS 916

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

E 46950

CERTIFICATE OF DEATH

E 46950

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 15-A WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edward Burton

(a) RESIDENCE NO. 1531 N. Gilmor ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., If foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lena Burton

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	43	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) ?
(State or country) Ga.

PARENTS

10 NAME OF FATHER Wilson Burton

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) Ga.

12 MAIDEN NAME OF MOTHER Caroline ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) Ga.

14 Informant Records

(Address) BALTIMORE CITY HOSPITALS

15 JUN 18 1929 HAMILTON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-16-29

17 I HEREBY CERTIFY, That I attended deceased from 6-15, 1929, to 6-16, 1929,

that I last saw him alive on 6-16, 1929

and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia, Rt. Lower

(duration) ... yrs. ... mos. 6 ds.

CONTRIBUTORY (Secondary) —— (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) Marion W. Miller, M. D.

, 19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem

DATE OF BURIAL 6-18 1929

20 UNDERTAKER Edw Lowson & Co

ADDRESS 916

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 46951

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 46951

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2412 Druid Hill Ave. WARD 29)

2-FULL NAME Mattie Bell Elizabeth Evans

(a) RESIDENCE No. 2412 Druid Hill Ave. WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem.

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year): 1910

7 AGE: Years 19 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): Domestic

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Harrison Evans

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore, Md

12 MAIDEN NAME OF MOTHER: Clara Cooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country): .....

14 Informant: Harrison M. Evans

(Address) 2412 Druid Hill Ave

15 Filed ..... 19 ..... HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 12/6/29

17 I HEREBY CERTIFY, That I attended deceased from 12/6/29, to 12/6/29, that I last saw h alive on 12/6/29, and that death occurred, on the date stated above, at 12.40 p.m.

The CAUSE OF DEATH* was as follows:

Heat exhaustion

about 36 hours

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Heat exhaustion

about 12 hours

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balto Md

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? No.

(Signed) E. Mayfield Boyd M. D.

(Address) 826 N. Carrollton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL 6-18-29

20 UNDERTAKER: David Easter — ADDRESS 916 Pa Ave

UNTOUCHED

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46952

E 46952

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PLACE OF DEATH

City of Baltimore: (No. 1033 W. Saratoga St. Ward) 18-16

2-FULL NAME Dantha Holmes

(a) RESIDENCE NO. 1033 W Saratoga St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 16 1928

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	1		1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work —
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) Balto City
(State or country)

PARENTS

10 NAME OF FATHER Robt Holmes

11 BIRTHPLACE OF FATHER (city or town) Va
(State or country)

12 MAIDEN NAME OF MOTHER Mame Youngstein

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Robt Holmes
(Address) 1033 W Saratoga

15 Filed ... G. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17 1929

17 I HEREBY CERTIFY, that I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Gastro Enteritis

(duration) ...yrs. 2 mos. ...ds.

CONTRIBUTORY (Secondary)

(duration) ...yrs. ...mos. ...ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. O. Browne, M. D.

June 18, 1929 (Address) 3601 33 St Brooklyn N.Y.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	6-18 1929
20 UNDERTAKER	ADDRESS
Dennis Eades	916 Eq ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 46953

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46953

CERTIFICATE OF DEATH

1-PLACE OF DEATH Pronounced dead at the

City of Baltimore: (No. South Baltimore General Hospital. Ward) 11-25

REGISTERED NO. 188-60

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Herbert Carver Getz.

(a) RESIDENCE NO. Y.M.C.A Building St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. ---- How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) January 9, 1906

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	23	5	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Waiter Liberty
(b) General nature of industry, business, or establishment in which employed (or employer) Lunch Room,
(c) Name of employer

9 BIRTHPLACE (city or town) Salisbury, Md.
(State or country)

PARENTS

10 NAME OF FATHER Charles Getz.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Salisbury Md,

12 MAIDEN NAME OF MOTHER Roxie Carver.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Hullwood, Va.

14 Informant Roxie Adkins. (mother)
(Address) 609 E. Chase St.

Filed JUN 18 1929 H. LEE JONES, M.D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture of the skull
Accidental Death

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) ----------

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Steinmetz Flying Field June 16, 1929

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquest

(Signed) Otto M. Leonhardt, M. D.

6/18, 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet DATE OF BURIAL June 20 1929

20 UNDERTAKER John F Denny ADDRESS 715 [illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46954

CERTIFICATE OF DEATH

E 46954

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. University Hospital WARD)

2—FULL NAME Emma E. Seiffert

(a) RESIDENCE NO. Ellicott City Md WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles Seiffert

6 DATE OF BIRTH (month, day, and year): Oct 20-1860

7 AGE: Years 68 Months 7 Days 18 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Jacob Uhl

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Magdalena

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Charles Seiffert

(Address): Ellicott City Md

15 [illegible] C. HARRISON JONES, M. D. Registrar

JUN 13 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 18, 1929

17 I HEREBY CERTIFY, That I attended deceased from 6/17/29, 19..., to 6/18/29 19..., that I last saw her alive on 6/18/29 19..., and that death occurred, on the date stated above, at 11.45 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Luther Leitz, M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: G. Johns Cemetery

DATE OF BURIAL: June 20 1929

20 UNDERTAKER: Mary E. Starr

ADDRESS: Ellicott City

Spec.—2-29-28—L. F. S.—500 Bks.

E 46955

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

38

E 46955

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Balto. City Hosp. ST. 21-31 WARD)

2—FULL NAME Harry Roberts

(a) RESIDENCE NO. 515 W. West ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 503 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Nek.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50 (?)			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer. 040

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown.

14 Informant (Address) Balto. City Hospitals, Balto., Md.

15 [illegible] 19 C. HAMPSON JONES, M. D. Registrar

N 181929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/16/29

17

I HEREBY CERTIFY, That I attended deceased from 4-11, 1929, to 6-16, 1929, that I last saw h[illegible] alive on 6-16, 1929 and that death occurred, on the date stated above, at 12.30 A m.

The CAUSE OF DEATH* was as follows:

General Paralysis of the insane

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Luetic infection

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical & Laboratory

(Signed) M. K. Lawans, M. D.

19 (Address) Balto City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Mt Auburn Cemt

DATE OF BURIAL 6-19 1929

20 UNDERTAKER Charles G. Cooper

ADDRESS 514 N. Calhoun St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 46956

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46956

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Franklin Square Hospital REGISTERED NO. 23

CITY OF BALTIMORE: (No. 225 S. Stricker ST., 14-28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace Elizabeth Deibel

(a) RESIDENCE NO. 225 S Stricker ST., ... WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Frances A Deibel

6 DATE OF BIRTH (month, day, and year) unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or .... min.
46				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Howard county Maryland

PARENTS

10 NAME OF FATHER Ruffin J. Duvall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary F Allen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Rose F Wagner (Address) 605 9th St N.E. Washington D.C.

15 Filed ... 19 ... C. HAMPSON JONES, M. D., Registrar

N 18 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17 1929

17 I HEREBY CERTIFY, That I attended deceased from June 17, 1929, to June 17, 1929, that I last saw her alive on June 17, 1929, and that death occurred, on the date stated above, at 1:50 P m.

The CAUSE OF DEATH* was as follows:

Cerebral oedema -

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of ...

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Arthur Kattenburg, M. D.

6/17, 1929 (Address) Franklin Sq Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL June 18th 1929

20 UNDERTAKER Robert Brookesson

ADDRESS Calhoun Hoffman

INFORMATION should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bka.

E 46957 (E 46957 31) HEALTH DEPARTMENT—CITY OF BALTIMORE E 46957

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 5-E WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Fred Miller

(a) RESIDENCE NO. 127 N. Exeter St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: B.

5 Single, Married, Widowed, or Divorced, (write the word): Mar

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 48 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: John

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Sarah Parker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Pa

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

15 [illegible] 19 [illegible] M. D.

Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 13 1929

17

I HEREBY CERTIFY, That I attended deceased from June 6, 1929, to June 13, 1929, that I last saw him alive on June 13, 1929, and that death occurred, on the date stated above, at 5:00 Am.

The CAUSE OF DEATH* was as follows:

Luetic aortitis; aortic insuff.

Syphilis

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary)

Bronchopneumonia (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Sa Gladstone, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL

DATE OF BURIAL 19

20 UNDERTAKER: [illegible] Inspector Health.

ADDRESS JUN 18 1929

N 18 1929

WRITE PLAINLY, WITH PENCIL OR PEN AND INK. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 46958

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 46958

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. 20-28 WARD 16-06 REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Harriet Stern

(a) RESIDENCE NO. 2251 Willows Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female

4 COLOR OR RACE white

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6-16-29.

7 AGE Years Months Days If LESS than 1 day hrs. or min. 9 hrs

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Thomas

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Amy Lynes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) West Virginia

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUN 18 1929 19 HARRISON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16 1929

17

I HEREBY CERTIFY, That I attended deceased from June 16, 1929, to June 16, 1929, that I last saw h[illegible] alive on June 16, 1929, and that death occurred, on the date stated above, at 7.20 p m.

The CAUSE OF DEATH* was as follows:

Premature b, atelectasis of lungs

(duration) yrs. mos. 5 hrs ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis? P Lung exam

(Signed) J. C. Goodwin M. D.

6/17, 1929 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS H[illegible] DATE OF BURIAL 19

20 UNDERTAKER [illegible] ADDRESS JUN 18 192[illegible]

WHITE PAPER, WITH CARBON. This certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46959 (E 22250) E 46959

CERTIFICATE OF DEATH.

41

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 9-46 (WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hazel Harris

(a) RESIDENCE NO. 2715 Frisby ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: negro

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years: — Months: 2 Days: If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Dan Beverly

11 BIRTHPLACE OF FATHER (city or town) (State or country): —

12 MAIDEN NAME OF MOTHER: Anna Harris

13 BIRTHPLACE OF MOTHER (city or town) (State or country): S. C.

14 Informant: Records
(Address): JOHNS HOPKINS HOSPITAL

15 Filed JUN 18 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17 1929

17 I HEREBY CERTIFY, That I attended deceased from June 13, 1929 to June 17, 1929, that I last saw her alive on June 17, 1929, and that death occurred, on the date stated above, at 4 A m.

The CAUSE OF DEATH* was as follows:

Streptococcus septicaemia

(duration) ..... yrs. ..... mos 14 ds.

CONTRIBUTORY (Secondary): —
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis? Blood culture

(Signed) H C Goodwin, M. D.

6/17, 1929 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL: 19

20 UNDERTAKER: [illegible] — ADDRESS: [illegible]

JUN 18 1929

M. D. WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 46960

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46960

CERTIFICATE OF DEATH

1-PLACE OF DEATH Pronounced dead at 18

City of Baltimore: (N) Balt City Hospital St., 25-76 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Cunningham

(a) RESIDENCE NO. 3206 Fairfield Rd St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 28 1908

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	20	9	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) Common
(c) Name of employer

9 BIRTHPLACE (city or town) Balt City
(State or country)

PARENTS

10 NAME OF FATHER James W Cunningham

11 BIRTHPLACE OF FATHER (city or town)
(State or country) South Carolina

12 MAIDEN NAME OF MOTHER Regina Clark

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) North Carolina

14 Informant James W Cunningham
(Address) 3206 Fairfield Ave

15 Filed 19 HAMPSON JONES, M. D.
Registrar
By W SINCLAIR Deputy

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Coroner, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning

(duration) Instant yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unascertained

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Accident

(Signed) James H Hamilton, M. D.

6/17/29 (Address) 700 Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary Cemetery — DATE OF BURIAL June 19 1929

20 UNDERTAKER Robert Williams per T Ellerson — ADDRESS 1313 Mc Elderry

N 18 1929

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-201

E 46961

CERTIFICATE OF DEATH

E 46961

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 415 N Charles ST., 4 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Bertha Cohen

(a) RESIDENCE NO. 415 N. Charles ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Apr 12, 1838

7 AGE: Years 91 | Months 2 | Days 7 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: David J. Cohen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Richmond, Va

12 MAIDEN NAME OF MOTHER: Harriett Cohen

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Swansea, Wales

14

Informant: Chas M. Cohen

(Address) 3012 Kendall Ave.

15

Filed ..., 19.. C. HAMPSON JONES, M. D. Registrar

N 18 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 18th 1929

17

I HEREBY CERTIFY, That I attended deceased from June 10th, 1929, to June 18th, 1929

that I last saw h alive on June 18th, 1929

and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis

Terminal Complication

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Hypostatic Pneumonia

(Signed) Jos. Eberhard, M. D.

June 18, 1929 (Address) 1301 E Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cohen Private Cem Saratoga

DATE OF BURIAL: 6/19 1929

20 UNDERTAKER: Henry W. Dunkin's Sons Co.

ADDRESS Orchard & Eutaw

IMPORTANT—Every question must be answered. Write plainly with ink. Use terms of exactness and avoid abbreviations. Make a separate certificate for each death. Do not use ditto marks. If unknown, state so. OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 46962

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46962

1—PLACE OF DEATH U. M. Hospital REGISTERED NO. 122-001

CITY OF BALTIMORE: (No. Severn Apt. ST., 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank K. Howard

(a) RESIDENCE NO. Severn ~~Southern~~ Apts. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 15, 1861

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
68	0	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Maryland

PARENTS

10 NAME OF FATHER Frank K. Howard

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Lida Morris

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md.

14 Informant Hospital records

(Address) U. M. H.

15 Filed ..... 19 ..... Registrar

101529 C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 25, 1929, 19..., to June 17, 1929,

that I last saw h.. alive on June 17, 1929

and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Atrophic Cirrhosis of Liver (alcoholic)

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis, Generalized

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. J. Seraphin, M. D.

6/17, 1929 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Old St Paul Cemetery	June 19, 1929
20 UNDERTAKER	ADDRESS
Henry W Jenkins Son &	Gilmor & McCulloh Sts

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46963 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 46963

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 925 N. Patterson Pk Ave. St., 7-12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Gertrude Killinger

(a) RESIDENCE NO. 925 N. Patterson Pk Ave. St.

(Usual place of abode)

WARD

Length of residence in city or town where death occurred 2 yrs. 2 mos. ds. How long in U. S., if foreign birth? 2 yrs. 2 mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 10th 1908

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20	6	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nurse

(b) General nature of industry, business, or establishment in which employed (or employer) Dr.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Ameil Killinger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Frieda Walter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Elisabeth Kelly.

(Address) 925 N. Patterson Pk. Ave.

15 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17/29

17 I HEREBY CERTIFY, That I attended deceased from June 4, 1929 to June 17, 1929

that I last saw her alive on June 17, 1929

and that death occurred, on the date stated above, at 2 40 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) yrs. 1 mos. 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-ray & Clinical signs

(Signed) Vincent V. Jaska, M. D.

, 19 (Address) 845 N. Patterson Pk Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Mem.

DATE OF BURIAL June 19 1929

20 UNDERTAKER Lilly & Zeiler Inc.

ADDRESS 403 S. Wolfe St.

N 18 1929

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46964 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44 E 46964

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4615 Elsrode Ave. ST. 27-44 WARD)

2—FULL NAME Catherine K. Seabreeze

(a) RESIDENCE NO. 4615 Elsrode Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 73 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John T. Seabreeze

6 DATE OF BIRTH (month, day, and year) Oct. 19, 1855

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
73	7	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John H. Kraft.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Frank T. Seabreeze

(Address) 4615 Elsrode Ave.

15 C. HAMPSON JONES, M. D.

Registrar

JUN 18 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18 1929.

17 I HEREBY CERTIFY, That I attended deceased from June 3, 1929, to June 18, 1929.

that I last saw h alive on June 17, 1929

and that death occurred, on the date stated above, at 8 A m.

The CAUSE OF DEATH* was as follows:

(Cardiac Failure)
(Myocarditis & Senile Sclerosis)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cancer of Liver & Ascites (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas Bowers, M. D.

June 19 1929 (Address) 4 McDonough Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Com. DATE OF BURIAL June 20 1929

20 UNDERTAKER Wm. G. Black ADDRESS 927 N. Broadway

IMPORTANT. PHYSICIANS should be careful to answer every question. Space should be filled in every case. Unknown or impossible answers should be stated. Write plainly. Use ink. Do not abbreviate. Write out full name and address. Do not use ditto marks. Be careful to fill in every question. Answer should be complete. Space should be filled in every case. Unknown or impossible answers should be stated. Write plainly. Use ink. Do not abbreviate. Write out full name and address. Do not use ditto marks. Be careful to fill in every question. Answer should be complete. OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 46965

HEALTH DEPARTMENT—CITY OF BALTIMORE

113 E 46965

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 319 Lunt ST. 24-33 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Raymond E. Hull

(a) RESIDENCE NO. 319 Lunt ST., 24 WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Dec 7 28

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		6	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Raymond E. Hull

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Estelle Collins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Estelle Hull (Address) 319 Lunt Ave

15 Filed JUN 18 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18-1929

17 I HEREBY CERTIFY, That I attended deceased from June 13, 1929, to June 18, 1929.

That I last saw h[illegible] alive on June 18, 1929

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Acute Gastro Enteritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C. Whelan M. D.

6/18, 1929 (Address) 1799 Williams Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Dodge Hill

DATE OF BURIAL 6/19 1929

20 UNDERTAKER J. Tobey Sons

ADDRESS 131 E Lights

IN 18 1929

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46966

CERTIFICATE OF DEATH

1-001 V

+ 101 E 46966

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Mt Sin Hosp St. N-W Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME James W Rhoten

(a) RESIDENCE NO. Hampstead St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 Color or Race W

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs James W Rhoten

6 DATE OF BIRTH (month, day, and year) Sept 11 1887

7 AGE Years 41 Months 9 Days 7

IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER James E Rhoten

11 BIRTHPLACE OF FATHER (City or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Addie Wilhelm

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant (Address) Hospt Records

15 C. HAMPSON JONES, M. D., Registrar

Dat

JN 18 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/18/29

17 I HEREBY CERTIFY, That I attended deceased from 6/18/29, 19..., to 6/18/29, 19..., that I last saw him alive on 6/18/29, 19..., and that death occurred, on the date stated above, at 3:10 P m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos. 1 4 ds.

CONTRIBUTORY (Secondary) Toxaemia

(duration) yrs. mos. ? ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No Clinical

What test confirmed diagnosis?

(Signed) Joseph Thompson, M. D.

6/18/29 (Address) Mt Sin Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Grace Cem. Balto Co

Date of Burial June 21 1929

20 UNDERTAKER Edw D Tipton

ADDRESS Hampstead Md

Spec.—2-29-28—L. F. S.—500 Bks.

E 46967 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46967

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 848 E. Pratt St ST., 3-5 WARD)

2—FULL NAME Jack Levinson

(a) RESIDENCE NO. Glenburnie Md ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of Edythe Levinson

6 DATE OF BIRTH (month, day, and year) Sept 15-1890

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
38	9	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Merchant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Meyer Levinson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Anna Abramovitz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Mrs Edythe Levinson

(Address) Glenburnie Md

JUN 19 1929 H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/18/29

17 I HEREBY CERTIFY, That I attended deceased from May 9, 1929, to June 18, 1929, that I last saw him alive on June 13, 1929, and that death occurred, on the date stated above, at 2.15 P. m.

The CAUSE OF DEATH* was as follows:

Subacute bacterial endocarditis.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemoplegia - cause ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? General Symptoms

(Signed) C. Andrew Gingold M. D.

6/18, 1929 (Address) 104 W. Madison St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mehren Rosedale — DATE OF BURIAL: 6/19 1929

20 UNDERTAKER: Jack Lewis — ADDRESS: 1409 E. Balt

IN CASE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46968

CERTIFICATE OF DEATH

57 E 46968

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 416 S. Stricker St. ST., 14-25 WARD)

2—FULL NAME Mary M. King

(a) RESIDENCE NO. 416 S. Stricker St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of Late James A. King

6 DATE OF BIRTH (month, day, and year) May 30, 1852.

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
77		17 18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Strauss

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mrs. Mary E. Griffin,

(Address) 416 S. Stricker St.

15 Filed JUN 19 1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17-1929

17 I HEREBY CERTIFY, That I attended deceased from June 1 1928, to June 17 1929, that I last saw h[illegible] alive on June 16 1929 and that death occurred, on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Death Due to

CONTRIBUTORY (Secondary) May Bronchitis (duration) 2 yrs. mos. ds.

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. W. Mitchell M. D.

4/8/29 (Address) 530 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL June 19, 1929

20 UNDERTAKER Harry N. Witzke 153 N. Embarg

ADDRESS

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46969

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

105 ✓ E 46969

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 500½ E. 42nd ST. 27-4 (WARD)

2—FULL NAME George H. Keen

(a) RESIDENCE NO. 500½ E. 42nd ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Widower

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 10-1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	4	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Produce

(b) General nature of industry, business, or establishment in which employed (or employer) Dealer

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Balt. Md.

PARENTS

10 NAME OF FATHER Austin Keen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary ann Jenkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant George H. Keen

(Address) 500½ E. 42nd St

15 Filed JUN 19 1929 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17-29

17 I HEREBY CERTIFY That I attended deceased from Jan 1923 to June 17 1929 that I last saw him alive on Jun 17 29 19 and that death occurred, on the date stated above, at 6 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Cystitis

History of 35 yrs standing

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute dilatation heart

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. W. Wheaton, M. D.

19 (Address) 4305 York Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
UNDERTAKER O'Conor & Whitmer	6/19 19 29
	ADDRESS 3 Eden E. Balto

Information should be carefully supplied. ARTS should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

Leroy Smith

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 46970

E 46970

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST., 12-51 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Leroy Smith

(a) RESIDENCE NO. 2204 Oak st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1911

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	18			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur 03

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Beatrice Taylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed ..... 19.... H. HAMILTON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16, 1929

17

I HEREBY CERTIFY, That I attended deceased from June 3, 19 29, to June 16, 19 29,

that I last saw h... alive on June 16, 19 29

and that death occurred, on the date stated above, at 12 noon m.

The CAUSE OF DEATH* was as follows:

Caseous pneumonia

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical and autopsy

(Signed) Henry Smith M. D.

6-17, 19 29 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Calvary Cem	June 19 29
20 UNDERTAKER	ADDRESS
Samuel J Kemsley	57 N Bridge

JUN 19 1929

IMPORTANT—This certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

46971

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46971

CERTIFICATE OF DEATH

38

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSPITALS ST., 6-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Krieger

(a) RESIDENCE NO. 1915 E. Fayette ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? ? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert Krieger

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 57

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) ? Russia

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ?

14 Informant (Address) Records of BALTIMORE CITY HOSPITALS

15 Filed JUN 19 1929, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-18-29

17 I HEREBY CERTIFY, That I attended deceased from 5-, 19 29, to 6-18, 19 29, that I last saw her alive on 6-18, 19 29, and that death occurred, on the date stated above, at 1130 A m.

The CAUSE OF DEATH* was as follows:

Syphilis of C.N.S. (Paresis)

" Tertiary Insuff.

? (duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes mellitus:

Arteriosclerosis (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy?

What test confirmed diagnosis? Phys. Exam. W.R. Blood Sugar

(Signed) Hampson Jones, M. D.

6-18, 19 29 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Dolphin Strong Run	6-19-1929
20 UNDERTAKER	ADDRESS
Pace Heine, 1739 E. Balto.	

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 46972

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46972

90

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Joseph Hospital St., 2-4 Ward)

2-FULL NAME Sarah E. Hartlove

(a) RESIDENCE NO. 1819 E. Pratt St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Hartlove

6 DATE OF BIRTH (month, day, and year) May 7/1879

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
50	1	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Beverly Stevens

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Sarah E. Stevenson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto., Md.

14 Informant George Hartlove (Son)
(Address) 1819 E. Pratt St

15 Filed JUN 19 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cardio-Renal Disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Obesity- Gangrene of rt. leg (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [illegible] M. D.

6/18/29 (Address) 503 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel Cem	June 20 1929
20 UNDERTAKER Lilly & Julian Sue	ADDRESS 403 S. Wolfe St

Spec.—1-10-21—M&T—1500 Blks.

E 46973

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 E 46973

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 215 W Henrietta St., 23-31 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jannie Dess

(a) RESIDENCE NO. 215 W Henrietta ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec - 5 - 1900

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
28	6	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer): Days Work

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country): West Point Virginia

PARENTS

10 NAME OF FATHER: Sam Dyree

11 BIRTHPLACE OF FATHER (city or town) (State or country): Newport Co Virginia

12 MAIDEN NAME OF MOTHER: Annie Allen

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Newport Co Virginia

14 Informant: Jannie Dass

(Address) Timonium Md.

Filed JUN 19 1929 HAMPSON L. JONES, M. D. Registrar

By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/18 1929

17 I HEREBY CERTIFY, That I attended deceased from 5-1/16, 1929, to 6/18, 1929, that I last saw h[illegible] alive on 6/17, 1929, and that death occurred, on the date stated above, at 9:30 P.M.

The CAUSE OF DEATH* was as follows:

Syphilis - (certain)

(duration) 2 yrs. — mos — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Hospital case

(Signed) Dan Drucker M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: West Point Va — DATE OF BURIAL: June 19 1929

20 UNDERTAKER: J L Brown & Son — ADDRESS: West Point

old Dominion

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 46974

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 46974

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Wexford-Kenoak Roads ST. 27-54 (WARD) 40

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Benson Dushane

(a) RESIDENCE NO. Wexford-Kenoak Roads ST., WARD Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. 6 mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie Chipman Dushane

6 DATE OF BIRTH (month, day, and year) Dec-1-1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	6	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manufactures 71

(b) General nature of industry, business, or establishment in which employed (or employer) Agent

(c) Name of employer Self

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER Nathan Dushane

11 BIRTHPLACE OF FATHER (city or town) ? ?

(State or country) Deleware

12 MAIDEN NAME OF MOTHER Mary E. Patterson

13 BIRTHPLACE OF MOTHER (city or town) Baltimore

(State or country) Maryland

14 Informant Mrs. Jennie Chipman Dushane (wife)

(Address) Wexford-Kenoak Roads, Mt. Washington

15 Filed [illegible] 19 C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17 1929

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1929, to June 17, 1929, that I last saw him alive on June 17, 1929, and that death occurred, on the date stated above, at 3.30 P m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Kidneys

(duration) 6 mos. ds.

CONTRIBUTORY (Secondary) Enlarged Heart

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symptoms

(Signed) William [illegible], M. D.

, 19 (Address) 2727 Druid Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	June-19-29 19

20 UNDERTAKER Stewart Memorial Co. Balto. ADDRESS

JN 19 1929

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46975

CERTIFICATE OF DEATH

123

E 46975

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 15-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rebecca Jane Markranty

(a) RESIDENCE NO. 5134 Westwood Ave. ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. ... mos. ... ds. How long in U. S., if foreign birth? — yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER Wm Reed

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md.

12 MAIDEN NAME OF MOTHER Catherine ?

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Records (Address)

15 Filed JUN 19 1929, 19 ... H. LLOYD JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-17-29

17 I HEREBY CERTIFY, That I attended deceased from 8-2, 19 26, to 6-17, 19 29, that I last saw h[illegible] alive on 6-17, 19 29 and that death occurred, on the date stated above, at 9-30 a.m.

The CAUSE OF DEATH* was as follows:

Cholecystitis

Cholelithiasis & obstruction

common duct

(duration) ... yrs. ... mos. 4 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis, Scoliosis, non-Tbc (duration) over 2 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home & here

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Course

(Signed) Marion W. [illegible] M. D.

19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	June 19 1929
20 UNDERTAKER	ADDRESS
Funeral System	1400 W North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JUN 19 1929

Spec.—1-10-21—M&T—1500 Bks.

E 46976

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1 6 1 001

E 46976

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital St. 7-4 WARD)

2-FULL NAME Baby Grossman

(a) RESIDENCE NO. 1745 E. Balto ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): S

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 17, 1929

7 AGE: Years — Months — Days: 18 hours 55 min. If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Paul Grossman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Lillian Eg Katz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Paul Grossman 1745 E Balto st

15 Filed JUN 19 1929, 19 — J. RAMSAY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18 1929

17

I HEREBY CERTIFY, That I attended deceased from June 17 '29 2.30 P.M. 1929 to June 18 1.55 P.M. 1929, that I last saw him alive on June 18 11 AM 1929, and that death occurred, on the date stated above, at 1 55 P.m.

The CAUSE OF DEATH* was as follows:

Prematurity 30 wks. gestation

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) A. A. Gotwals, M. D.

6/19 1929 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Hebrew Run — DATE OF BURIAL: 6/19 1929

20 UNDERTAKER: Jos Lowndes & Bro — ADDRESS 112 E Balto St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46977 — CERTIFICATE OF DEATH — E 46977

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hosp ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ethel Rush

(a) RESIDENCE NO. University Hospital ST., WARD Towson Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

a If married, widowed, or divorced HUSBAND of (or) WIFE of James B. Rush

6 DATE OF BIRTH (month, day, and year) April 3. 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	2	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) At Home

(c) Name of employer Herself

9 BIRTHPLACE (city or town) (State or country) New Hampshire

PARENTS

10 NAME OF FATHER Augustus P. Peters

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Hampshire

12 MAIDEN NAME OF MOTHER Alice Lovell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Phoenix

14 Informant James B. Rush

(Address) 1014 Bolton Street

15 Filed JUN 19 1929, 19 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 16, 1929 to June 19, 1929

that I last saw h alive on June 19, 1929

and that death occurred, on the date stated above, at 5:30 A m.

The CAUSE OF DEATH* was as follows:

Acute pancreatitis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Diabetes

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of June 17, 1929

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Henry Vincent Davis M. D.

6-19, 1929 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Prospect Hill	June 21 1929
20 UNDERTAKER Foley Burns Son	ADDRESS Towson

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 46978 HEALTH DEPARTMENT—CITY OF BALTIMORE

112 E 46978

CERTIFICATE OF DEATH.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should use CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3202 Mc Elderry St. 26-11 WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Catherine Fermes or Le
(or Catherine)

(a) RESIDENCE No. 3202 Mc Elderry ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Joseph Fermes

6 DATE OF BIRTH (month, day, and year) Aug 18 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	10		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer) —
(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS
10 NAME OF FATHER unknown
11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy
12 MAIDEN NAME OF MOTHER unknown
13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Andrew J. Finn
(Address) 3202 Mc Elderry

15 Filed JUN 19 1929 C. HAMPSON JONES, M. D. Registrar
By .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18 1929

17 I HEREBY CERTIFY, That I attended deceased from June 15 1929 to June 18 1929, that I last saw her alive on June 18 1929, and that death occurred, on the date stated above, at 12 Noon.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Senile Debility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Joseph L. Valentano M. D.

(Address) 14 So Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL June 21, 1929

20 UNDERTAKER Frank V. Pipitone — ADDRESS 2518 E. Baltimore

JUN 19 1929

Spec.—2-29-28—L. F. S.—500 Bks.

E 46979 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-09

E 46979

1—PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO.

CITY OF BALTIMORE: (No. 27-43 ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George W. Peltzer

(a) RESIDENCE NO. 4310 Mary Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? — yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary D. ~~Peltzer~~ Peltzer

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General natore of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Francis Peltzer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Henrietta A. ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Records of

(Address) Baltimore City Hospitals

15 Filed JUN 19 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 17, 1929 to June 19, 1929

that I last saw h.im alive on June 19, 1929

and that death occurred, on the date stated above, at 1:45 A. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

Acute myocardial failure } over

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Morphinism addiction 5 mos

Cerebral neurosis (duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Exam. Autopsy

(Signed) Marion H. McLean M. D.

6-19, 1929 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

Asbury M.E. Cemetery June 22 1929

20 UNDERTAKER J. F. Edens Sons Co. ADDRESS

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46980

101-001 V

E 46980

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. ... ST., 3-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Leila Hawkins

(a) RESIDENCE NO. 419 S. Caroline ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if foreign birth? — yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Unknown

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Records of

(Address): Baltimore City Hospitals

15 Filed: 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 18, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 17, 1929 to June 18, 1929 that I last saw h... alive on June 18, 1929 and that death occurred, on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) ... yrs. ... mos. 6 ds.

CONTRIBUTORY (Secondary): None

(duration) — yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Thomas [illegible], M. D.

6-19, 1929 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cemtry	June 20 1929
20 UNDERTAKER	ADDRESS
Robert F. Williams	1515 McElderry St

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46981 51 E 46981

CERTIFICATE OF DEATH

1—PLACE OF DEATH Union Memorial Hospital. REGISTERED NO.

CITY OF BALTIMORE: (No. 12-50 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Edwin Annen

(a) RESIDENCE NO. 3035 Barclay St ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 10/20/27

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	~~7~~ 8	~~20~~ 30	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto, Md
(State or country)

PARENTS

10 NAME OF FATHER J. Henry Annen

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Md

12 MAIDEN NAME OF MOTHER Sylvia Granbard

13 BIRTHPLACE OF MOTHER (city or town) Winstead
(State or country) Conn.

14 Informant Hospital records
(Address)

15 Filed JN 19 1929 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/19/29

17 I HEREBY CERTIFY, That I attended deceased from June 17, 1929, to June 19, 1929, that I last saw him alive on June 19, 1929 and that death occurred, on the date stated above, at 12 40 A.m.

The CAUSE OF DEATH* was as follows:

Cardiac insufficiency secondary to acute rheumatic mitral insufficiency & stenosis.

(duration) yrs. mos. 2 1 ds.

CONTRIBUTORY (Secondary) Acute Rheumatic fever

Bronchopneumonia (duration) yrs. mos. ? ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm H. McFaul jr. M. D.

, 19 (Address) Union Memorial Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Govans	June 21st 1929
20 UNDERTAKER	ADDRESS
Wm Cook	1217 St Paul

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46982

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

L 100-001

E 46982

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. University Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ira G. Vickers

(a) RESIDENCE NO. Pylesville, Md. ST.. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Vickers

6 DATE OF BIRTH (month, day, and year) June 1. 1900

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	29		18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Elec Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) 029

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Edwin Vickers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn

12 MAIDEN NAME OF MOTHER Margaret Carter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Mary Vickers

(Address) York Pa

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

UN 191929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/19/29

17

I HEREBY CERTIFY, That I attended deceased from 6/15, 1929, to 6/19, 1929

that I last saw him alive on 6/18, 1929

and that death occurred, on the date stated above, at 8 30/A m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

Septicemia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Osteomyelitis, right humerus (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Charles E. Gill, M. D.

6/19, 1929 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL York Penn

DATE OF BURIAL 6-20 1929

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46983 (49)

E 46983

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3414) (Street) Brantley Rd (WARD) 5-6

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ernest VanCleve Baugh

(a) RESIDENCE NO. 3414 (Street) Brantley Rd. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. 2 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced, HUSBAND of (or) WIFE of Josephine E. Baugh

6 DATE OF BIRTH (month, day, and year) Dec 21, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	56	5	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Mgr. Cemetery Supt. Dining

(b) General nature of industry, business, or establishment in which employed (or employer): Car Service

(c) Name of employer: B & O R.R.

9 BIRTHPLACE (city or town) (State or country): Hinfield Sweden

PARENTS

10 NAME OF FATHER: Joel E. Baugh

11 BIRTHPLACE OF FATHER (city or town) (State or country): Wis.

12 MAIDEN NAME OF MOTHER: Mary C. Swenson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Sweden

14 Informant: Mrs. Josephine E. Baugh

(Address): 3414 Brantley Rd

15 HAMPSON JONES, M. D. Registrar

JUN 20 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18, 1929

17

I HEREBY CERTIFY, That I attended deceased from April 4th, 1929 to June 18, 1929

that I last saw h im alive on June 18, 1929

and that death occurred, on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Infiltrating carcinoma of Bladder

Myocardial failure

(duration) yrs. mos.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 4/23/29

Was there an autopsy? no

What test confirmed diagnosis? Thorough examination

(Signed) B. S. Abrahams, M. D.

19 (Address) 330 N. Chas St.

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	June 20, 29

20 UNDERTAKER: Wm J Fickner Son — ADDRESS: N Pa

I. Be sure every item is answered. If unknown, say so. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46984

CERTIFICATE OF DEATH

129 E 46984

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3024 Edmondson Ave ST. 16-70 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Simms

(a) RESIDENCE NO. 3024 Edmondson Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 78 yrs. — mos. — ds. — How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

If married, widowed, or divorced — HUSBAND of (or) WIFE of: William C. Simms

6 DATE OF BIRTH (month, day, and year): June 20-1850

7 AGE — Years: 78 Months: 11 Days: 27 If LESS than 1 day, hrs. or min.: 28

8 OCCUPATION OF DECEASED

(a) Trade, professinn or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Myers

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: William C. Simms

(Address) 3024 Edmondson Ave

15 Date: JUN 20 1929 C. HAMILTON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 17-1929

17 I HEREBY CERTIFY, That I attended deceased from May 25 . 1929 . to June 17 . 1929 . that I last saw her alive on June 17 . 1929 and that death occurred, on the date stated above, at 2:10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
Arteriosclerosis

(duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary): Cerebral apoplexy and uremia (duration) — yrs. 2 mos. 24 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Maurice E. Shamer M. D.

6/18 . 1929 (Address) 3300 N. Charles Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dorsey Mount — DATE OF BURIAL: June 20 19 29

UNDERTAKER: D. J. Cushwa Sr — ADDRESS: N. A. Pa

A.—WRITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD. Any mistake or omission should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. AGE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 46985

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 46985

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Johns Hopkins Hospital ST., WARD)

REGISTERED NO. 159-06 E 46985

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sally Schweitzer

(a) RESIDENCE NO. 706 N. Fenwood ST. Ave. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 15, 1929

7 AGE Years Months Days: 4

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Vernon Schweitzer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sadie Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant

(Address)

Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19 1929

17 I HEREBY CERTIFY, That I attended deceased from 6-15, 1929 to 6-19, 1929 that I last saw her alive on 6-19, 1929 and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Convulsions of Pregnancy

Duration

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Hamilton Ward M. D.

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem DATE OF BURIAL June 20 1929

20 UNDERTAKER A. Howard Evans ADDRESS 28 E. Fayette St.

JUN 20 1929

Cor.—12-9-25—A Co.—200 Bks.

Hanna H. Johnson.

HEALTH DEPARTMENT—CITY OF BALTIMORE

46986

CERTIFICATE OF DEATH.

E 46986

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2122 N. Charles St. 12-51 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Hanna H. Johnson

(a) RESIDENCE NO. 2122 N. Charles St. 12 Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If ~~married~~ widowed, or ~~divorced~~ ~~HUSBAND~~ of (or) WIFE of: W. H. Johnson

6 DATE OF BIRTH (month, day, and year): 2 2 about 1859

7 AGE: Years: about 70 | Months: 2 | Days: 12 | IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Baltimore

(State or country): Maryland

PARENTS

10 NAME OF FATHER: Joshua Hall

11 BIRTHPLACE OF FATHER (city or town): Balto.

(State or country): Md.

12 MAIDEN NAME OF MOTHER: Rena Childs

13 BIRTHPLACE OF MOTHER (city or town): Balto.

(State or country): Md.

14 Informant: Mrs. Clara Wilson

(Address): 45 [illegible]

JUN 20 1929

, 19

Per

HAMILTON JONES, M. D.

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6-18 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, aut- topsy or inquiry.) find that said deceased came t death on the day stated above.

The CAUSE OF DEATH* was as follows:

Senile Dementia

Senility (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(Signed) (Coroner) M. D.

6/19 1929 (Address) 3532 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs., mos., ds. In the State yrs., mos., ds.

Where was disease contracted, if not at place of death?

2122 N Charles St.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — Date of Burial: June 1 1929

20 UNDERTAKER: Hughes & Goods — ADDRESS: 1114 N. Broadway

E

FOR.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—7-17-26—A Co.—200 Bks.

46987

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

16 VE 46987

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Md. Gen. Hosp. St. 15-61 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy King

(a) RESIDENCE NO. 3308 W. Garrison Ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male

4 Color or Race White

5 Single, Married, Widowed, or Divorced, (write the word) Infant.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6-18-29

7 AGE Years Months Days IF LESS than 1 day 0 hrs. or 20 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Md. Gen. Hosp. Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER James King

11 BIRTHPLACE OF FATHER (City or town) Balto. Md.

(State or country)

12 MAIDEN NAME OF MOTHER Nina McFarland

13 BIRTHPLACE OF MOTHER (city or town) Phila. Pa

(State or country)

14

Informant Hospital records.

(Address)

15 Filed JUN 20 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-18-29 19

17

I HEREBY CERTIFY, That I attended deceased from 7:40 P.M. 6-18 1929 to 8:00 P.M. 6-18- 1929 that I last saw h alive on 8:00 P.M. 6-18- 1929 and that death occurred, on the date stated above, at 8:00 P. m.

The CAUSE OF DEATH* was as follows:

Congenital atelectasis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) None.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Laboratory

6/19/29 (Signed) Jno G Sampson M. D.

(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Centreville Md. Date of Burial June 20 1929

20 UNDERTAKER Mr. Mrs John W. Tenfelde ADDRESS 801 W. Fayette

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS very important. See instructions on back of certificates.

E

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46988

1—PLACE OF DEATH

REGISTERED NO. E 46988

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 916 N. Broadway (ST.) (WARD) 13

2—FULL NAME Cecelia Fink

(a) RESIDENCE NO. 916 N. Broadway ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if foreign birth 45 yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Late Solomon

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 75 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER: Louis Fink

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Ida Uk.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Mrs Fink

(Address) 916 N Broadway

15 Filed JUN 20 1929, 19 — C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 19/29

17 I HEREBY CERTIFY, That I attended deceased from Jan — 19 29 to June 19 19 29

that I last saw her alive on June 19 19 29

and that death occurred, on the date stated above, at 5:15 p m.

The CAUSE OF DEATH* was as follows:

Cerebral Thrombosis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Chronic myocarditis

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) Edward Doran, M. D.

19 (Address) Medical Arts Bldg.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Washington Rd

DATE OF BURIAL: June 21 19 29

20 UNDERTAKER: Sol Levinson & Bro

ADDRESS 1127 E Balto St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 46989

REGISTERED NO. E 46989

1-PLACE OF DEATH

City of Baltimore: (No. Johns Hopkins Hospital St., 7-9 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Evelyn Kues

(a) RESIDENCE NO. Rosedale, Md. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 3 mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F.	W.	S.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Mar 26/1926

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	3	2	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Rosedale, Md.
(State or country)

PARENTS

10 NAME OF FATHER Frederick J. Kues

11 BIRTHPLACE OF FATHER (city or town)
(State or country) B alto., Md.

12 MAIDEN NAME OF MOTHER Dora Simpson

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto., Md.

14 Informant Frederick J. Kues
(Address) Rosedale, Md.

15 [illegible] HARRY JONES, M. D.
Registrar

JUN 20 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobular Pneumonia
Fibrous Pericarditis
Abcesses in Kidney
Subacute Meningitis (duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? yes Date of Skull depression

Was there an autopsy? yes at Hopkins

What test confirmed diagnosis?

(Signed) J. H. Wilson, M. D.

19 (Address) 506 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	June 21 1929

20 UNDERTAKER Martin W. E. Hoffman ADDRESS 37 Leonard

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 46990

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-001

E 46990

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West Baltimore Gen'l Hosp (ST.) (WARD)

2-FULL NAME Mrs Celia Liberman

(a) RESIDENCE NO. 458 South Spring St (ST.) WARD

(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? 23 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Usreal Liferman

6 DATE OF BIRTH (month, day, and year): 8 6 4

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min
65	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Jack Lewis

(Address) 1439 E Balt St

15 Filed JUN 20 1929, 19 C. HAMILTON JONES, M. D., Registrar

Per LLL

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/19 1929

17 I HEREBY CERTIFY, That I attended deceased from June 19, 1929 to June 19, 1929

that I last saw her alive on June 19, 1929

and that death occurred, on the date stated above, at 3:05 P m

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Typical findings

(Signed) Benj. Barnhart M. D.

, 19 (Address) West Balto Gen'l Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Nursery

DATE OF BURIAL: 6/20 1929

20 UNDERTAKER: Jack Lewis

ADDRESS: 1439 E Balt St

INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE is very important. See instructions on back of certificates. Exact statement of OCCUPATION

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46991
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

46 E 46991

CITY OF BALTIMORE: (No. 207 S. Calhoun ST., 19 WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura A. Leibel

(a) RESIDENCE No. 207 S. Calhoun ST., 19 WARD
(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Married

6 DATE OF BIRTH (month, day, and year): May 21st 82

7 AGE: Years 47. Months Days 26. If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS
10 NAME OF FATHER: James E. Godwin
11 BIRTHPLACE OF FATHER (city or town) (State or country): Md
12 MAIDEN NAME OF MOTHER: Emma Mayhew
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Wallace Leibel
(Address) 207 S Calhoun St

15 Filed JUN 20 1929 C. HAMPSON JONES, M. D. Registrar
By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 17 1929

17
I HEREBY CERTIFY, That I attended deceased from May, 1929, to June 16, 1929, that I last saw h— alive on June 16, 1929, and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) yrs. 3 mos. ds.
CONTRIBUTORY (Secondary): Uterine Hemorrhage
(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.
June 19 1929 (Address) 2687 Greenmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem. DATE OF BURIAL June 20 1929

20 UNDERTAKER: A. Jones ADDRESS 111 S. Gilmor
21

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46992

CERTIFICATE OF DEATH

90 E 46992

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 669 Portland ST. 22-3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Fredrick Meyer

(a) RESIDENCE NO. 669 Portland ST., WARD
(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., If foreign birth? 59 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs. Mary Meyer

6 DATE OF BIRTH (month, day, and year) Jany 12 - 1850

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
79	5	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lesse Germany

PARENTS

10 NAME OF FATHER Fredrick Meyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lesse Germany

12 MAIDEN NAME OF MOTHER Minnie Bubre

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary Meyer

(Address) 669 Portland St

JUN 20 1929 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18, 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 25, 1929, to June 18, 1929, that I last saw h[illegible] alive on June 18, 1929 and that death occurred, on the date stated above, at 3 30 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis 5 yrs

Chr. Endocarditis 3 "

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sphygmomanometer + auscultation

(Signed) J M Orlett, M. D.

June 19, 1929 (Address) 621 Washington Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	6/22/29
20 UNDERTAKER	ADDRESS
Geo Lenhardt & Son	529 Lyndhurst

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. All information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 lks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46993

CERTIFICATE OF DEATH

43

E 46993

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3303 Ravenwood Ave (ST.) 8-40 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Saunders

(a) RESIDENCE NO. 3303 Ravenwood Ave (Usual place of abode) WARD

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Katherine M. Saunders

6 DATE OF BIRTH (month, day, and year): Nov 15/1877

7 AGE: Years 51 | Months 7 | Days 4 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Brakeman

(b) General nature of industry, business, or establishment in which employed (or employer): B & O R.R.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Wm Wesley Saunders

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Mary K. —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

11 Informant: Katherine M. Saunders

(Address) 3303 Ravenwood Ave

15 C. HAMILTON JONES, M. D. Registrar

JUN 20 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 19/29

17 I HEREBY CERTIFY, That I attended deceased from May 11th, 1929, to June 19th, 1929, that I last saw him alive on June 18th, 1929, and that death occurred, on the date stated above, at 6 a.m.

The CAUSE OF DEATH* was as follows:

Sarcoma, primary in left lower jaw.

(duration) 1 yr. 6 mos. — ds.

CONTRIBUTORY (Secondary) Hemorrhage,

(duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death? At place of death.

Did an operation precede death? No. Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Clinical & microscopical.

(Signed) C. W. S. Rohrer, M. D.

19 (Address) 2814 Ailsa Avenue.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dulaney Valley — DATE OF BURIAL: June 21 1929

20 UNDERTAKER: Philip Lewis — ADDRESS: 2046 Orleans St

IMPORTANT.—WRITE PLAINLY WITH LEAD PENCIL. Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46994

CERTIFICATE OF DEATH.

124 E 46994

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 867 Richard St., 12-24 WARD)

2-FULL NAME Josephine Thompson

(a) RESIDENCE NO. 867 Richard ST., ... WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 17-1852

7 AGE Years 77 Months 4 Days 7 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Richard E Thompson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Rachel Sayers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Lenderschyn

(Address) 867 Richard St

15 Filed JUN 28 1929 WILLIAM H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/18/1929

17 I HEREBY CERTIFY, That I attended deceased from 6/15/29, 19 6/18/29, 19 ....

that I last saw h alive on 6/18/29, 19 ....,

and that death occurred, on the date stated above, at 10 pm.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. 3 mos ..... ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) yrs. ..... mos. 6 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Stephen Dami M. D.

, 19 (Address) 1127 N Bond

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pikesville Cemetery DATE OF BURIAL June 21 1929

20 UNDERTAKER John F Fields ADDRESS 1201 W Lombard St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

Spec.—7-17-26—A Co.—200 Bks.

46995

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 46995

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Md. Gen. Hospital Street (or Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frederick A Grasch

(a) RESIDENCE NO. 1220 W. Lombard Street Ward

(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 Color or Race: white

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Martha Heuschen Grasch

6 DATE OF BIRTH (month, day, and year): Sept. 23, 1856.

7 AGE — Years: 72 Months: 8 Days: 25 IF LESS than 1 day.....hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Grocer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Frederic Grasch

11 BIRTHPLACE OF FATHER (City or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER:

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Alberta Grasch

(Address): 1220 W. Lombard

15 [illegible] 19 [illegible]

C. HAMPSON JONES, M. D. Registrar

per [signature]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 17 19 29

17 I HEREBY CERTIFY, That I attended deceased from 6·15 19 29 to 6·17 19 29

that I last saw h.. alive on 6·17 19 29

and that death occurred, on the date stated above, at 8-40 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Urethral Stricture

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute retention of urine

and Hypostatic Pneumonia (duration) yrs. mos. 24 hrs

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

6/18/29

(Signed) Jno A Gouldstone M. D.

(Address) Md Gen Hospr

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loraine Cem. Date of Burial: June 21 19 29

20 UNDERTAKER: John L Fields ADDRESS: 1100 W Lombard

JUN 20 1929

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-12-23—M&T—500 Bks.

Barney.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46996

E 46996

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1065 Argyle Ave ST 17-24 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha V Barney

(a) RESIDENCE No. 1065 Argyle ST, WARD

(Usual place of abode)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col.	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John W Barney

6 DATE OF BIRTH (month, day, and year) 1875 ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Don't know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) John W. Barney 1065 Argyle Ave

15 Filed JUN 20 1929, 19 Per C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 17 1929

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1929, to June 17, 1929, that I last saw h alive on June 16 1929 and that death occurred, on the date stated above, at 4:30 a m

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? X-ray

(Signed) [illegible], M. D.

, 19 (Address) 1065 Argyle Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem DATE OF BURIAL 6-20-1929

20 UNDERTAKER Harris Easton ADDRESS 916 Dolphin

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 46997 HEALTH DEPARTMENT—CITY OF BALTIMORE E 46997

CERTIFICATE OF DEATH.

REGISTERED NO. 8-13 100

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Univ Hosp. (St.) (Ward)

2-FULL NAME Edward Bone.

(a) RESIDENCE NO. 1706 Biddle St. ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 18 1927

7 AGE: Years 1 Months 10 Days 1 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balt Md

PARENTS

10 NAME OF FATHER Edward Bone

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balt Md

12 MAIDEN NAME OF MOTHER Sarah Bone

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balt Md

14 Informant Edward Bone (Address) 1706 Biddle St

15 Filed JUN 20 1929 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/11 1929

17 I HEREBY CERTIFY, That I attended deceased from 5/21 1929 to 6/11 1929, that I last saw h[illegible] alive on 6/11 1929, and that death occurred, on the date stated above, at 12:45 A m.

The CAUSE OF DEATH* was as follows:

Bilateral Pneumonia

with Empyema Thoracis.

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Bronchopneumonia.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of —

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy

(Signed) A. H. Colvin, M. D.

, 19 (Address) Univ Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: June 19

20 UNDERTAKER: [illegible]

ADDRESS: [illegible]

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-12-23—M&T—500 Blks.

E 46998

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46998

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hospital ST. 25-12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary L. Reinicker

(a) RESIDENCE NO. German Orphan Home ST., ... WARD .....
(Usual place of abode) Catonsville, Md.
Length of residence in city or town where death occurred life yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): ~~Married~~ ~~Widowed~~ Divorced

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Harold G. Reinicker

6 DATE OF BIRTH (month, day, and year): June 23, 1877

7 AGE: 49 Years: 52 Months: 11 Days: 26 If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED: Asst Supt.

(a) Trade, profession or particular kind of work: ~~Housekeeper~~

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: German Orphan Home

9 BIRTHPLACE (city or town): Baltimore
(State or country): Maryland

PARENTS

10 NAME OF FATHER: Albert Gallagher

11 BIRTHPLACE OF FATHER (city or town)
(State or country): United States

12 MAIDEN NAME OF MOTHER: Louisa Pietsche

13 BIRTHPLACE OF MOTHER (city or town): Baltimore
(State or country): Maryland

14 Informant: Mrs Ida Dallam
(Address) 2008 E. 31 St

Filed JUN 20 1929 C. HAMPSON JONES, M. D.
By ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6-18 1929

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1929, to June 18, 1929, that I last saw her alive on June 18, 1929, and that death occurred, on the date stated above, at 5:55 P m.

The CAUSE OF DEATH* was as follows:

Septicemia

(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary): Cellulitis of Cervical region

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of 6-10-29

Was there an autopsy? No

What test confirmed diagnosis? Blood culture

(Signed) Grace E. Smith M. D.

6/19 29 (Address) 704 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cemetery

DATE OF BURIAL: June 21, 29

20 UNDERTAKER: Roach & Cook

ADDRESS: 1003 West Baltimore St.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 46999

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 46999

CERTIFICATE OF DEATH

N. B.—WRITE PLAINLY, with UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 3015 Guilford Ave St., 12th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Mary Becker

(a) RESIDENCE NO. 3015 Guilford Ave ST., 12th WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. 1 mos. ds. How long in U. S., if foreign birth? 64 yrs. 1 mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Becker

6 DATE OF BIRTH (month, day, and year) Nov 18th 1844

7 AGE Years	Months	Days	If LESS than 1 day, 1 hrs. or 2 min.
84	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. — None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Joseph Linnenberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Sophia —?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant E A Becker

(Address) 3015 Guilford Ave

15 Filed JUN 20 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 5, 1929 to June 19, 1929

that I last saw h[illegible] alive on June 19, 1929

and that death occurred, on the date stated above, at 7 30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) B L Rickard M. D.

6/20, 1929 (Address) 320 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ghost. St. John Redeemer's — DATE OF BURIAL 6 22 1929

20 UNDERTAKER Henry W. Jenkins' Sons Co — ADDRESS Balto-Mt Cutler-

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47000

CERTIFICATE OF DEATH

E 47000

REGISTERED NO. 25-729

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2516 Huron St. Ward)

2-FULL NAME John Wesley Crawford

(a) RESIDENCE NO. 2516 Huron St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col.	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary Crawford

6 DATE OF BIRTH (month, day, and year) April 2- 1887

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	42	2	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Waiter at S.
(b) General nature of industry, business, or establishment in which employed (or employer) Penna. Station
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Samuel T. Crawford

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Gertrude Gittle

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto. Md

14 Informant Gertrude Crawford
(Address) 2516 Huron St

Filed JUN 20 1929 C. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6 16 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Indigestion
Chronic Myocarditis
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?
Did an operation precede death? Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Chas. O'Donnell, M. D.
6/18. 1929 (Address) 3601 3rd St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	June 20, 29
20 UNDERTAKER Samuel J. Hemsley	ADDRESS 1 E Biddle

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47001 — CERTIFICATE OF DEATH. — E 47001

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1-PLACE OF DEATH

City of BALTIMORE: (No. St Agnes Hospital 25-72 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Lissa K Burns

(a) RESIDENCE NO. 5313 7th St N.W. Washington D.C.
(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry Burns

6 DATE OF BIRTH (month, day, and year) Sept. 15 1883

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	45	9	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer) Work at Home

(c) Name of employer

9 BIRTHPLACE (city or town) Hampton

(State or country) Va.

PARENTS

10 NAME OF FATHER Peter Gilgen

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Harold Burns Husband

(Address) 5313 7th St Washington D.C.

Filed ..... 19.. HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-19 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Crushing of chest Contussion Lungs — due to an auto accident — the said accident caused by blowout of rear tire & crossing into East driveway of Mr. Forsch & overtake into data

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) +5' deep & tumors on the cerebrum

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) H. J. Jones M. D.
(Coroner)

6/19, 1929 (Address) 2939 Mc Elderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death? Elkridge Md

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hampton Mausoleum Date of Burial June 19, 1929

20 UNDERTAKER Edwin W. Conkelin ADDRESS 9248 Eng

Spec.—2-29-28—L. F. S.—500 Bks.

E 47002 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47002

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO. 18-16 129

CITY OF BALTIMORE: (No. Arthur ST., or WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Woodson

(a) RESIDENCE NO. 112 N. Poppleton ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? — yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	~~Unknown~~ Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Loretta Woodson ~~Unknown~~

6 DATE OF BIRTH (month, day, and year) Jan 2, 1885 ~~Unknown~~

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	43	5	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman

(b) General nature of industry, business, or establishment in which employed (or employer) Brass Steel furnaces

(c) Name of employer ?

9 BIRTHPLACE (city or town) Dale of Wight Co
(State or country) Virginia

PARENTS

10 NAME OF FATHER Edward Woodson

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Lucy Harris

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) Virginia

14 Informant Records of
(Address) Baltimore City Hospitals

15 JUN 20 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1929, to June 18, 1929, that I last saw him alive on June 18, 1929 and that death occurred, on the date stated above, at 6:40 P. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis & edema & hypertension,

Chronic myocarditis

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Phys. Exam. Blood & P.M.

(Signed) Marvin [illegible] M. D.

6-19, 1929 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery — DATE OF BURIAL June 22, 1929

20 UNDERTAKER Mrs. Katie R. Williams — ADDRESS 322 N. Schroeder St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Molloy

47003

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 E 47003

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

E

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1320 Ensor ST. 918 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Leo Molloy

(a) RESIDENCE NO. 1320 Ensor ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Margaret Molloy

6 DATE OF BIRTH (month, day, and year) Jan 7, 1837

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or min.
	40	5	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stone-cutter

(b) General nature of industry, business, or establishment in which employed (or employer) Cut stone Contractors

(c) Name of employer Clough & Molloy

9 BIRTHPLACE (city or town) Baltimore, (State or country) Md.

PARENTS

10 NAME OF FATHER Laurence Molloy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary J. Rowlins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Mary Molloy (wife)

(Address) 1320 Ensor St.

15 C. HAMPSON JONES, M. D. Registrar

JUN 20 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18, 1929

17 I HEREBY CERTIFY, That I attended deceased from Mar 15, 1929, to June 18, 1929, that I last saw him alive on June 18, 1929 and that death occurred, on the date stated above, at 5 15 P. m.

The CAUSE OF DEATH* was as follows:

Metastatic Carcinoma

(duration) 2 yrs. 3 mos ds.

CONTRIBUTORY (Secondary) Carcinoma Liver

(duration) 3 yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 24, 1928

Was there an autopsy? No.

What test confirmed diagnosis? Physical Evidence

(Signed) Geo. C. Dyer, M. D.

19 (Address) 2852 Harford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	June 21 1929

20 UNDERTAKER Rita Medefield ADDRESS 914 Greene Ave

Spec.—2-29-28—L. F. S.—500 Bks.

E 47004

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129

E 47004

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. 9-46 ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Nik Bikulchius Or Bikulcius

(a) RESIDENCE NO. 2564 Aisquith ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. — mos. ds. — How long in U. S., if foreign birth 20 yrs. — mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced BUSBAND of (or) WIFE of Helen Bikulchius

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Simon Bikulchius

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Victoria ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records of
(Address) Baltimore City Hospitals

15 JUN 20 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 7, 19 29, to June 18, 19 29, that I last saw h im alive on June 18, 19 29 and that death occurred, on the date stated above, at 9:30 P. m.

The CAUSE OF DEATH* was as follows:

Thrombosis r Ant Cerebral artery & left Hemiplegia

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Chronic nephritis (Arteriosclerotic)

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Phys Exam Autopsy

(Signed) Warren H. Wheeler M. D.

6-19, 19 29 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	June 21. 1929
20 UNDERTAKER	**ADDRESS**
John Grebliauckas	423 S Paca ST.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47005

CERTIFICATE OF DEATH.

162

E 47005

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hosp ST. 14-30 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alfred Vaughan

(a) RESIDENCE NO. Provident Hosp ST., 0 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: aa

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 6-14-29

7 AGE: Years — Months — Days 4 — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto Md (State or country)

PARENTS

10 NAME OF FATHER George Muse

11 BIRTHPLACE OF FATHER (city or town) unknown (State or country)

12 MAIDEN NAME OF MOTHER Annie Vaughan

13 BIRTHPLACE OF MOTHER (city or town) Balto Md (State or country)

14 Informant Mother

(Address) 220 Arlington Ave

15 C. HAMPSON JONES, M. D. Registrar

JUN 20 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-18-1929

17 I HEREBY CERTIFY, That I attended deceased from 6-14-1929 to 6-18-1929 that I last saw him alive on 6-18-1929 and that death occurred, on the date stated above, at 3 50 A. m.

The CAUSE OF DEATH* was as follows:

Hemorrhagic disease of Newborn

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? yes

What test confirmed diagnosis? Ordinary

(Signed) Wm H. Frazier M. D.

(Address) Provident Hosp 6-18-1929

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS JUN 19 1929

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Varicek

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47006 — **E 47006**

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 19-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jaroslaw Varicek

(a) RESIDENCE NO. 612 N. Chester St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
51				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) Tailoring

(c) Name of employer Self.

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Varicek

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Zamecka

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant

(Address) Dorothy 612 N. Chester St

15 Filed JUN 28 1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/20/29

17 I HEREBY CERTIFY, That I attended deceased from 6/18, 1929, to 6/20, 1929, that I last saw him alive on 6/19/, 1929, and that death occurred, on the date stated above, at 8:30 A.M.

The CAUSE OF DEATH* was as follows:

Endocarditis. Myocarditis. Cardiac Hypertrophy & dilatation

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Rheumatism

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Charles E. Hill, M. D.

6/29, 1929 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cole Hill Cem — DATE OF BURIAL June 23 1929

20 UNDERTAKER Frank Crook & Son — ADDRESS 1916 Eastern Ave

IMPORTANT—Name should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47007

CERTIFICATE OF DEATH

X 188-001

E 47007

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Mercy Hospital. St. M-1 Ward)

2-FULL NAME Edward Lester Harman.

(a) RESIDENCE NO. Bowie, Md. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) August 9, 1909

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	19	10	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer Pa.R.R.Co.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Bowie, Md.
(State or country)

PARENTS

10 NAME OF FATHER Edward L.Harman.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) A.A.Co.Md.

12 MAIDEN NAME OF MOTHER Edna Donaldson.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) A.A.Co.Md.

14 Informant Edward Harman.(father)
(Address) Bowie, Md.

Filed JUN 20 1929, 19 C. HAMILTON JONES, M. D., Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry.
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Crushed about the left leg. by Pa.R.R. Engine. Accidental death.
Amputation of left leg at knee.
Shock. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Bowie, Md. June 19, 1929
Did an operation precede death? Yes. Date of June 19, 1929
Was there an autopsy? No.
What test confirmed diagnosis? Inquiry
(Signed) Otto H. Reinhardt, M. D.
6/20. 1929 (Address) 1019 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Patuxent Md — DATE OF BURIAL June 21 1929

20 UNDERTAKER M. J. Ladenheim — ADDRESS Bowie Md

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 blks.

Reuben Dunlop.

E 12 05

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47008
REGISTERED NO.

1—PLACE OF DEATH
CITY OF BALTIMORE: (No. University Hospital ST. 22-30 WARD)
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Reuben Dunlop

(a) RESIDENCE NO. 531 Burgundy St. ST.
(Usual place of abode) WARD
Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Daisy

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	37			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Fireman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ga.

PARENTS
10 NAME OF FATHER
11 BIRTHPLACE OF FATHER (city or town) (State or country)
12 MAIDEN NAME OF MOTHER
13 BIRTHPLACE OF MOTHER (city or town) (State or country)

A. K. Talley, M.D. Eugene Talley, M.D.

14
Informant
(Address)

15 Filed JUN 20 1929 J. HAMPSON JONES, M. D. Registrar
By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 6th, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 2nd, 1929, to June 6th, 1929, that I last saw him alive on June 6th, 1929, and that death occurred, on the date stated above, at 7.20 p.m.

The CAUSE OF DEATH* was as follows:
Intestinal obstruction 16 hrs

CONTRIBUTORY (Secondary) Cirrhosis of liver, alcoholic (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Home (duration) yrs. 3 mos. ds.

Did an operation precede death? Yes Date of 6-2-29

Was there an autopsy?

What test confirmed diagnosis? Operation

(Signed) Chas. E. Tuttle, M. D.
6-6-1929 (Address) University Hospital

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL JUN 20 1929

20 UNDERTAKER [illegible] Director of Health.

ADDRESS

IMPORTANT—Answer every question by stating fact. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47009

CERTIFICATE OF DEATH

E 47009

1—PLACE OF DEATH Balto City Hospt 6-21-29 ✓ REGISTERED NO.

CITY OF BALTIMORE; (No. Balto Md ST. 26-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Guy Corcoran

(a) RESIDENCE NO. Unknown ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
50				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Balto City Hospt

(Address) Balto Md

15 [illegible] HAMPSON JONES, M. D. Registrar

JUN 20 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-17-29

17 I HEREBY CERTIFY, That I attended deceased from 6-16, 1926 to 6-17, 1929

that I last saw him alive on 6-16, 1929

and that death occurred, on the date stated above, at 4.30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Myocardial Failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Dementia Praecox

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Harry H. Hamm M. D.

6/19/29 Address Balto City Hospt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional spare.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem 6/22/29 DATE OF BURIAL 19 1929

20 UNDERTAKER Leonard J Ruck

ADDRESS 6405 Jeffries Ave

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47010

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 V

E 47010

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1427 N. Eugene ST. 14-23 WARD)

2—FULL NAME John W. Metzler

(a) RESIDENCE NO. 1427 N. Eugene ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE Henrietta Metzler

6 DATE OF BIRTH (month, day, and year) August 9, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	10	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment In which employed (or employer) Gen Co.

(c) Name of employer Kelly Gen Co.

9 BIRTHPLACE (city or town) (State or country) Washington D. C.

PARENTS

10 NAME OF FATHER John Metzler

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Lutkunch

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Henrietta Metzler

(Address) 1427 Eugene St

N 201929 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18, 29

17 I HEREBY CERTIFY, That I attended deceased from May, 1927, to June, 1929, that I last saw h.. alive on June 3, 1929 and that death occurred, on the date stated above, at 10:15 P. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonalis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage

(duration) yrs. mos. 16

18 Where was disease contrarted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis?

(Signed) H. S. Hart, M. D.

6-20-1929 (Address) 715 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	June 21 1929
20 UNDERTAKER Wm Cook	ADDRESS 1717 Pratt

If DEATH occurred in a State other than that in which you reside, this form should be filled out in accordance with the laws of the State in which death occurred. Use ink and write plainly. Cross out words not applicable. Use blanks for "Unknown." Fill in all items. Information is required by law and is very important. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 47011

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 47011

1-PLACE OF DEATH Franklin Square Hospital — REGISTERED NO. 90

CITY OF BALTIMORE: (No. Cathcart + Saratoga ST., 77-42 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry Stocker.

(a) RESIDENCE NO. 5644 Belair Road ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna Stocker.

6 DATE OF BIRTH (month, day, and year): Sept. 16th 1873

7 AGE — Years: 55 — Months: 9 — Days: 5 — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Grocer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: William Stocker

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Margaret Kreiling

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Anna Stocker

(Address) 5644 Belair Road

15 C. HARRISON JONES, M. D. Registrar

JUN 20 1929

Per R.D.C.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 19 1929

17

I HEREBY CERTIFY, That I attended deceased from June 17, 1929, to June 19, 1929,

that I last saw him alive on June 19, 1929,

and that death occurred, on the date stated above, at 2:20 P m.

The CAUSE OF DEATH* was as follows:

Rheumatic cardiac disease

& mitral stenosis + insufficiency

(duration) 49 yrs. mos. ds.

CONTRIBUTORY (Secondary) auricular fibrillation + Cardiac decompensation 5 yrs?) (duration) mos. ds.

18 Where was disease contracted if not at place of death? home.

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? clinical findings

(Signed) Elizabeth B. Sherwin, M. D.

6/19, 1929 (Address) Franklin Square Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: June 22, 1929

20 UNDERTAKER: Frederick Sasse & Sons — ADDRESS: Fullerton

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47012

CERTIFICATE OF DEATH

24 E 47012

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) Maryland General Hosp St.. 9-47 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Thelma E. Foreman

(a) RESIDENCE NO. 862 W. 33rd St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. 3 mos. 9 ds. How long in U. S. if of foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

N 201929

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 10 1923

7 AGE — Years: 6 Months: 3 Days: 9 IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Balto. Md.

(State or country)

PARENTS

10 NAME OF FATHER: Jas. R. Foreman

11 BIRTHPLACE OF FATHER (City or town) (State or country): Balto - Md.

12 MAIDEN NAME OF MOTHER: Bessie H. Baker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md.

14 Informant: Hospital Record

(Address)

15 Filed C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19: 6/19/29

17 I HEREBY CERTIFY, That I attended deceased from 6-19-29, 19 to 6-19, 19 29.

that I last saw her alive on 6-19, 19 29.

and that death occurred, on the date stated above, at 10:20 P. m.

The CAUSE OF DEATH* was as follows:

Cerebro-spinal Meningitis (Epidemic).

(duration) 0 yrs. 0 mos. 1? ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

6/19/29 (Signed) Jno. A. Foreman, Jr. M. D.

(Address) 1 W. Eutaw Place

*State the Disease Causing Death, or if deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery Date of Burial 6/21 1929

20 UNDERTAKER: J. Walter Davis ADDRESS 3307 Paine St

Spec.—2-29-28—L. F. S.—500 Bks.

E 47013 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

161-001 E 47013

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1011 Sharp ST. 3-3) REGISTERED NO.

2—FULL NAME Baby Johnson (If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 1011 Sharp ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	single

a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) 6/19/29

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ✓

(b) General nature of industry, business, or establishment in which employed (or employer) ✓ Nil

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Isaac Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Martha Wadd

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Richmond Va

14 Informant Isaac Johnson

(Address) 1011 Sharp st

15 Filed JUN 20 1929 C. HAMPSON JONES, M. D. Registrar

N 201929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/19/29

17 I HEREBY CERTIFY, That I attended deceased from 6/19, 1929, to 6/19, 1929, that I last saw him alive on 6/19, 1929, and that death occurred, on the date stated above, at 11.45 P. m.

The CAUSE OF DEATH* was as follows:

Premature Delivery (6½ mo)

(doration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) [illegible], M. D.

. 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

JUN 20 192

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 47014 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47014

CERTIFICATE OF DEATH.

REGISTERED NO. 38

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 927 McCulloh St. WARD 11-24)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Williams

(a) RESIDENCE NO. 927 McCulloh St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
M	colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6-11-29

7 AGE	Years	Months	Days	If LESS than 1 day 1 hrs or min.
			0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Willis Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Suffolk Va

12 MAIDEN NAME OF MOTHER Mary B. Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington D.C.

14 Informant (Address)

15 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-20 1929

17 I HEREBY CERTIFY, That I attended deceased from 6-11, 1929, to 6-20, 1929, that I last saw h alive on 6-11-, 1929, and that death occurred, on the date stated above, at 1-45 m.

The CAUSE OF DEATH* was as follows:

Atelectasis & Pre-maturity

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Syphilis (?)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Luetin reaction

(Signed) John W. Brunn M. D.

, 19 (Address) 1701 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

JOHNS HOPKINS HOSPITAL

Commissioner Health.

JUN 20 1929

JUN 20 1929

...mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should ... CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA-TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 47015 HEALTH DEPARTMENT—CITY OF BALTIMORE

47015

E 470_

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE; (No.) 5926 Falls Rd ST. 27 (WARD) 54

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Thomas Welsh

(a) RESIDENCE NO. 5926 Falls Rd ST., 27 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If ~~married, widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~: Mary E. Welsh

6 DATE OF BIRTH (month, day, and year): March 2-1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	3	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: RR Watchman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: P.R.R.

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Wm. Welsh

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Quinn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs. Bridget

(Address) 5926 Falls Rd

15 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/16/29

17 I HEREBY CERTIFY, That I attended deceased from Sudden, 1929, to 1/2 hour 1929, that I last saw him alive on 6/16/29, 1929, and that death occurred, on the date stated above, at 5:00 a.m.

The CAUSE OF DEATH* was as follows:

Coronary Embolism

& Chronic Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Brights

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical only

(Signed) Henry F. Coyle, M. D.

6/16 1929 (Address) 1 Upland Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge — DATE OF BURIAL: June 1 1929

20 UNDERTAKER: Joan F. Durant — ADDRESS: West Fulton Rd.

N 20 1929

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47016

CERTIFICATE OF DEATH

E 47016

1—PLACE OF DEATH University Hospital REGISTERED NO. 70-69

CITY OF BALTIMORE: (No. ..... ST., ... WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lawrence Leary

(a) RESIDENCE NO. 2714 W Fairmount WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Gertrude Leary

6 DATE OF BIRTH (month, day, and year) May 15 1887

7 AGE Years 42 Months 1 Days 3 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman

(b) General nature of industry, business, or establishment in which employed (or employer) B & O R R

(c) Name of employer Shops

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Patrick Leary

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Elizabeth Murphy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Gertrude Leary

(Address) 2714 W Fairmount

15 Date 19 C. HAMPSON JONES, M. D.

Registrar

JUN 20 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18th, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 12th, 1929, to June 15th, 1929, that I last saw h alive on June 15th, 1929 and that death occurred, on the date stated above, at 8:15 A.m.

The CAUSE OF DEATH* was as follows:

Acute General Peritonitis

(duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary) Paralytic ileus

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 6-12-29

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) Geo. H. Fowler, M. D.

6-18-, 1929 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem DATE OF BURIAL 6/21 1929

20 UNDERTAKER Joseph Fahey ADDRESS Fulton & Fayette

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47017

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47017

CERTIFICATE OF DEATH

1—PLACE OF DEATH St Joseph Hospital REGISTERED NO. 49

CITY OF BALTIMORE: (No. Caroline & ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ellen Langgood

(a) RESIDENCE NO. 320 Caroline ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Charles L. Langgood

6 DATE OF BIRTH (month, day, and year) 1-10-1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	58	5	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Martin Connelly

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Margaret —?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Charles L. Langgood.

(Address) 320 Caroline St.

15 C. HAMPSON JONES, M. D. Registrar

N 201929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-17-29

17 I HEREBY CERTIFY, That I attended deceased from 5-22-29 19 to 6-17-29 19

that I last saw h alive on 6-17-29 19

and that death occurred, on the date stated above, at 9.45 P m.

The CAUSE OF DEATH* was as follows:

Cancer of Lung

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchio-Pneumonia

(duration) yrs. mos. 7 ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? no Date of none

Was there an autopsy? yes 6-17-29

What test confirmed diagnosis? Autopsy

(Signed) W B Hurdiff, M. D.

(Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	6-21 19 29
20 UNDERTAKER	ADDRESS
Martin Feeney & Sons	847 W Fayette

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47018

CERTIFICATE OF DEATH

E 47018

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 16 E. Gen Hosp (St.) 15-58 (Ward)

2-FULL NAME Charles E. Anderson

(a) RESIDENCE No. 3724 Reisterstown Rd., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: None

6 DATE OF BIRTH (month, day and year): Oct 29-1864

7 AGE: Years 64 | Months 7 | Days 25 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Helper Dryd Hill pat.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or county): Queen Anne's
(State or country): Md.

PARENTS

10 NAME OF FATHER: Wm Anderson

11 BIRTHPLACE OF FATHER (State or country): Queen Anne's Md.

12 MAIDEN NAME OF MOTHER: Frances Ross

13 BIRTHPLACE OF MOTHER (State or country): Queen Anne's Md.

14 Informant: Frances Bradley
(Address): 3721 Reisterstown Rd

15 Filed ..... C. HAMPSON JONES, Registrar.
By .....

N 201929

CORONER'S CERTIFICATE OF [illegible]

16 DATE OF DEATH (month, day, and hour): June 19 [illegible] 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH was (Accident)
Pulmonary Thrombosis
Fractured Both Legs
Fell down elevator Shaft
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Lived Hill pat

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Regnelon Hartsuck, M. D.
Coroner

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Bethel Cem. Cecil Co. Md.

DATE OF BURIAL: June 21 1929

20 UNDERTAKER: Wm. J. Tickner & Son

ADDRESS: North & Pa

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

(Kleinsnitz)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47019

CERTIFICATE OF DEATH

E 47019

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Md Gen. Hosp St. 11-24 Ward)

2-FULL NAME John W. Co Kleinsnitz

(a) RESIDENCE NO. Hamstead Md St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: ~~Male~~

4 Color or Race: White

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): August 8, 1877

7 AGE — Years: 51 | Months: 10 | Days: 10 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Farm Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town)
(State or country): Maryland

PARENTS

10 NAME OF FATHER: Joseph Kleinsnitz

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Germany

12 MAIDEN NAME OF MOTHER: Anna Rosenberg

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Germany

14 Informant: Carroll Kleinsnitz
(Address): Hampstead Md

15 Filed ....., 19 .....

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6-18 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest
(Inquest, autopsy or inquiry)
find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fract (Occipital) Skull due to fall from tree upon which he was today — (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): accidental
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Black Rock Rd

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) I J Frame, M. D.

6/20, 1929 (Address) 2939 Mc Elderry

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Wesley Cem. Carroll Co. ~~Hampstead, Md~~ DATE OF BURIAL: June 21 1929

20 UNDERTAKER: Wm. J. Tickner & Sons ADDRESS: North & Pa Ave

JUN 20 1929

C. HAMPSON JONES, M. D.

RPW

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

(Charlotte Blum)

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47020

188-103

E 47020

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Franklin Sq Hosp St. (Ward)

2-FULL NAME Charlotte Blum

(a) RESIDENCE NO. 438 N Brice St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
F	W	Child

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —none—

6 DATE OF BIRTH (month, day, and year) 11 24 - 23

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	5	7	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER Francis Blum

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Maude Ambach

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Francis Blum
(Address) 438 Brice St

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

N 201929 By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-18 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Comp. Comminuted fract left leg Joint - Pulmonar Condition due to injs Struck by auto Bus and run over accidental (Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia Double & Hard of Tampa Fla (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Franklin & Brice

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. Hampson Jones M. D.

6/20 1929 (Address) 29 39th Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL June 21 1929

20 UNDERTAKER Chenoweth & Son — ADDRESS 3615 Clinton

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47021

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47021

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1907 Wilkins Ave ST., (WARD) 20-28

2—FULL NAME Emma A. Miller

(a) RESIDENCE NO. 1907 Wilkins Ave ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred 66 yrs. 4 mos. 21 ds. How long in U. S., if foreign birth? yrs. mos. ds.

REGISTERED NO. 129
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Jas. A. Miller

6 DATE OF BIRTH (month, day, and year): Jan 30 - 1863.

7 AGE: Years 66 | Months 4 | Days 21 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer): —
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Edward Ritter

11 BIRTHPLACE OF FATHER (city or town) (State or country): Berlin Germ.

12 MAIDEN NAME OF MOTHER: Lautermann

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Berlin. Germ.

14 Informant: Mathilda L. Dunlap
(Address) 1907 Wilkins Ave

15 C. HAMPSON JONES, M. D.
Registrar

UN 201929 Pd

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 20/29

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1929, to June 20, 1929, that I last saw h[illegible] alive on June 20, 1929, and that death occurred, on the date stated above, at 3 26 P. m.

The CAUSE OF DEATH* was as follows:
Arteriosclerosis - Chronic Interstitial Nephritis - Mitral Stenosis

CONTRIBUTORY (Secondary) Influenza Pneumonia (duration) yrs. mos. 20 ds.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Robert C. Kitzel, M. D.
6/20/29 (Address) 2157 William Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	June 24th 29
UNDERTAKER	ADDRESS
S. S. Kupfert	155 N. Bond St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks. Dr. Conser 1101 N. Fulton Ave

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47022 — CERTIFICATE OF DEATH — **E 47022**

6-24-29

1—PLACE OF DEATH

REGISTERED NO. 16-32

CITY OF BALTIMORE: (No. 1011 N. Payson St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Lizzie Hellings

(a) RESIDENCE NO. 1011 N. Payson ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 52 yrs. 1 mos. 2 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6 a If married, widowed or divorced HUSBAND of (or) WIFE of: Frank T. Hellings

6 DATE OF BIRTH (month, day, and year): May 16th 1877

7 AGE: Years 52 Months 1 Days 2 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Herman Schminger

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore, Md.

12 MAIDEN NAME OF MOTHER: Louise Gunder

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore, Md.

14 Informant: Mrs. Herman Day

(Address) 1011 N. Payson St.

Filed JUN 20 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 18th 1929

17 I HEREBY CERTIFY, That I attended deceased from 11-2 1929, to 6-18 1929

that I last saw h[er] alive on 6-18 1929

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Central Haemorrhage (Apoplexy)

(duration) 2 yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary): Circulatory Hypertension Unknown (duration) mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? —

(Signed) Chas. C. Conser, M. D.

6/19, 1929 (Address) 1101 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: June 21st 1929

20 UNDERTAKER: H. D. Hilpert — ADDRESS: 1850 W. Balto St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

Spec. 1-10-21 M&T 1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47023

CERTIFICATE OF DEATH.

E 47023

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3421 W. Baltimore St. WARD 27-56

2-FULL NAME Mrs. Kate Stehle

(a) RESIDENCE NO. 3421 W. Baltimore ST., WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 72 yrs. 6 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 ~~Single, Married~~, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Peter Stehle

6 DATE OF BIRTH (month, day, and year) Jan 30 = 1856

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs or ....min.
	72	6	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) =

(c) Name of employer =

9 BIRTHPLACE (City or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Jacob Hoffmeister

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaretha

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Elizabeth Stehle
(Address) 3421 W. Balto St.

15 Filed JUN 20 1929, 19.. Registrar C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-20-1929

17 I HEREBY CERTIFY, That I attended deceased from 6-10-1929, to 6-20-1929.

that I last saw her alive on 6-20-1929.

and that death occurred, on the date stated above, at 7.10 a.m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerosis.

Several Yrs. (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Endocarditis.
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of none

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Amerigo Lorelli M. D.

6/20 1929 (Address) 3705 Liberty Hgts Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery DATE OF BURIAL June 22 1929

UNDERTAKER H. S. Hufnagel ADDRESS 1850 W. Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JUN 20 1929

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47024

CERTIFICATE OF DEATH

E 47024

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1623 Fairmount Ave ST., 8-45 WARD)

2—FULL NAME James Madison Smith.

(a) RESIDENCE NO. 1623 Fairmount Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Virginia Smith

6 DATE OF BIRTH (month, day, and year): May 5 1890

7 AGE: Years 39 | Months 1 | Days 14 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer): Automobiles

(c) Name of employer: Hudson Co.

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Henry N. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Rose McIntyre

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Virginia Smith wife

(Address): 1623 Fairmount Ave

15 Filed 6-24 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 19 1929

17 I HEREBY CERTIFY, That I attended deceased from June 9, 1929 to June 19 1929

that I last saw him alive on June 19, 1929

and that death occurred, on the date stated above, at 5 13 P. M.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) yrs. 8 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? None

(Signed) Thos. A. Stevens M. D.

6/19 1929 (Address) 2878 Hartford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: 6/22 1929

20 UNDERTAKER: Henry W. Meears and Son — ADDRESS: 605 N. Calvert

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47025

CERTIFICATE OF DEATH

88 E 47025

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3228 Pressman ST., WARD) 16-67

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Catharine A. Mead

(a) RESIDENCE NO. 3228 Pressman ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. — mos. 10 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of the late Walter Mead

6 DATE OF BIRTH (month, day, and year) June 19 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	—	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Robert Shields

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mr. Joseph A. Mead

(Address) 3228 Pressman St

Filed JUN 21 1929, 19

15 C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20 1929

17 I HEREBY CERTIFY That I attended deceased from June 17th, 1929, to June 20th, 1929.

that I last saw her alive on June 20th, 1929

and that death occurred, on the date stated above, at 7:30 A m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

CONTRIBUTORY (Secondary) Poxie hypertension, Senility (duration) yrs. mos. ds.

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? at place of death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) D. Edgar Fay M. D.

6/20 1929 (Address) 2919 Belmont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	June 22 1929
20 UNDERTAKER	ADDRESS
Kenny Hoen Sons, Inc.	1301 E Eager St

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47026

CERTIFICATE OF DEATH

129 E 47026

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 872. W. Fairmount Ave (St.) (1 8 - 26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Louisa Gray

(a) RESIDENCE NO. 872. W. Fairmount Ave St., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 COLOR OR RACE: Col.

5 ~~Single, Married~~, Widowed, or ~~Divorced~~, (write the word): Widow

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: Henry Gray

6 DATE OF BIRTH (month, day, and year): Aug 16-1856

7 AGE: 72 Years 73 | Months 10 9 | Days 4 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ellicott City Md

PARENTS

10 NAME OF FATHER: Allen Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Maria Blaze

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Ella Gray

(Address) 872. W. Fairmount Ave

15 Filed ... 19... C. HANSON JONES, M. D. Registrar

JN 21 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 20/29

17

I HEREBY CERTIFY, That I attended deceased from June 1, 1929, to June 20, 1929

that I last saw h.. alive on June 19, 1929

and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Chr. Interstitial Nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Degeneration

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urinalysis

(Signed) D. M. Card M. D.

6/30. 1929 (Address) 2005 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: National Cem — DATE OF BURIAL: June 23, 1929

20 UNDERTAKER: Sam'l M. Chase Son — ADDRESS: 1400 Mosher

IMPORTANT.—Please write plainly in ink, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47027 — 129 — E 47027

1—PLACE OF DEATH Balto City Hospt — REGISTERED NO.

CITY OF BALTIMORE: (No. Balto Md ST. 17-26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Addie Edwards

(a) RESIDENCE NO. 916 (Usual place of abode) Shields Place ST. — WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1892

7 AGE: Years 37 ? | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Virginia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Balto City Hospt

(Address) Balto Md

15 Filed JUN 21 1929, 19 — C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6-19-29

17 I HEREBY CERTIFY, That I attended deceased from 5-23-, 19 29 to 6-19, 19 29

that I last saw her alive on 6-19, 19 29

and that death occurred, on the date stated above, at 10.30? m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis Myocardial Disease

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Psychosis Cardio Renal Insufficiency

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical findings

(Signed) Wm H Worrall, M. D.

6/20, 1929 (Address) Balto City Hospt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: MtAuburn Cem — DATE OF BURIAL: 6-22 19 29

20 UNDERTAKER: Daniel Gaston — ADDRESS 916 Eo. Ave

IMPORTANT. See instructions on back of certificates. Exact statement of OCCUPATION is very important. See instructions on back of certificates. DEATH in plain terms, so that it may be properly classified.

Spec.—1-12-23—M&T—500 Bks.

E 47028

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1 29

E 47028

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1613 Riggs ave. 6-23 (WARD)

2-FULL NAME Albert Brown

(a) RESIDENCE No. 1613 Riggs ST, ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 53 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	Col.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Virginia Brown

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
53	—	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Charles Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Matilda Wallace

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Virginia Brown
(Address) Edgewater Md

15 Filed ..., 19... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-20- 1929

17 I HEREBY CERTIFY, That I attended deceased from 5-21-, 1929, to 6-20-, 1929, that I last saw him alive on 6-19-, 1929 and that death occurred, on the date stated above, at 2,30 P. m

The CAUSE OF DEATH* was as follows:

Valvulites

(duration) unknown. yrs. mos ds.

CONTRIBUTORY (Secondary) Interstitial Nephritis

(duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) [illegible] M. D.

6-20-, 1929 (Address) 611-N. Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Adams Chapel — DATE OF BURIAL 6-23 1929

20 UNDERTAKER Daniel Easton — ADDRESS 916 Eager ave

N 211929

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should take

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47029

CERTIFICATE OF DEATH.

44 E 47029

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1804 Division ST. 14-20 (WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nathaniel Mackel

(a) RESIDENCE NO. 1804 Division ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colord	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah Mackel

6 DATE OF BIRTH (month, day, and year) June 5, 1862

7 AGE Years	Months	Days	If LESS than 1 day, hrs or min.
67	0	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Hotel

(b) General nature of industry, business, or establishment in which employed (or employer) Pantry-man

(c) Name of employer Maryland Club, Annandale Co

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Nathaniel Mackel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Asco

12 MAIDEN NAME OF MOTHER Mary Shaomel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Calvert Co Md

14 Informant Sarah Mackel

(Address) 1804 Division St

15 Filed ..... 19 ..... C. HANSON JONES, M. D. Registrar

Ref. RDC

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19 19 29

17 I HEREBY CERTIFY, That I attended deceased from May 31, 19 29, to June 19, 19 29, that I last saw him alive on June 18, 19 29, and that death occurred, on the date stated above, at 9.35 A. m.

The CAUSE OF DEATH* was as follows:

Gastric Carcinoma (Pylorus)

(duration) yrs. 6 mos ? ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No X-Ray - History

What test confirmed diagnosis? X-Ray

(Signed) Wm H Wright M. D.

6/19, 19 29 (Address) 1209 Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sharp St Cem. Frederick Md — DATE OF BURIAL June 23 29

20 UNDERTAKER Samuel H Wesley — ADDRESS 578 N Bond

JUN 27 1929

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Florence L. Donohue.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47030

CERTIFICATE OF DEATH

E 47030

1—PLACE OF DEATH St Joseph's Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. Caroline St. WARD) 5 (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Florence Lawrendrue

(a) RESIDENCE NO. 244 Broadway St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Donahue.

6 DATE OF BIRTH (month, day, and year) Feb. 19, 1869.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	60	4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER J. D. Donohue.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Mrs. M. Donohue.

(Address) 432 Lorraine Ave

Filed JUN 21 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/20/29

17 I HEREBY CERTIFY, That I attended deceased from 6-3-29, 19..., to 6-20-29 19...,

that I last saw h... alive on 6-20-29 19...

and that death occurred, on the date stated above, at 11.9 m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 10 ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? Yes Date of 6/13/29

Was there an autopsy? No

What test confirmed diagnosis? Clinical course

(Signed) N B Hendrix, M. D.

19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olive Cem

DATE OF BURIAL 6/21 1929

20 UNDERTAKER A Herman Lemmon.

ADDRESS 54 E. 22nd

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47031

CERTIFICATE OF DEATH

E 47031

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 533 N Hanover St., 7-31 Ward)

2-FULL NAME Cecelia Burns

(a) RESIDENCE NO. 533 N. Hanover St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Patrick Burns

6 DATE OF BIRTH (month, day, and year) Dec-25-1865

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
63	2	4	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Char Woman
(b) General nature of industry, business, or establishment in which employed (or employer) Industrial
(c) Name of employer Bldgs

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Owen Fahey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Cath Fahey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Cath Fahey

(Address) 533 N Hanover

15 Filed JUN 21 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Came to her death the result of Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Ran into & was knocked down by auto 6-15-29 down by Nicolas Trimble & the death was accidental & from result

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? accidental

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) H. Mann M. D.

1929 (Address) 29 39th & Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters — DATE OF BURIAL 6-22-1929

20 UNDERTAKER Bernard C Harle — ADDRESS 1000 S Paca St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 47032

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47032

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH

REGISTERED NO. 19-28

CITY OF BALTIMORE: (No. 204 S. Fulton Ave., ST.; WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Elizabeth Long

(a) RESIDENCE. No. 204 S. Fulton Ave., ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 5-1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	2	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seamstress

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Christopher Boette

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Louisa Thum

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Mary W. Kuhlen
(Address) 204 S. Fulton Ave.,

15 Filed JUN 21 1929 C. HARRISON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept-27, 1928, to June 19, 1929, that I last saw h alive on June 18, 1929, and that death occurred, on the date stated above, at 7 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Adema

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Carcinoma

(duration) yrs. 8 mos. 22 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Progressive

(Signed) M. D.

6/19/29 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cemetery DATE OF BURIAL June 21 1929

20 UNDERTAKER George L. Schwartz ADDRESS Frederick Ave

PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. AGE should be stated EXACTLY. If born within one year, state age in months or days. Informant should be carefully supplied.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47033

CERTIFICATE OF DEATH.

E 47033

1-PLACE OF DEATH Sinai Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. Monument & Rutland ST. 15-61 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Adolph Mankowitz

(a) RESIDENCE No. 2871 W. Garrison av ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? 27 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1901

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
28	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Gov't

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Hyman Mankowitz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Anna Swoff

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Hyman Mankowitz (Address) 2871 W. Garrison Ave

15 Filed JUN 21 1929 H. C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-21 1929

17 I HEREBY CERTIFY, That I attended deceased from 5-31, 1929, to 6-21, 1929, that I last saw h/m alive on 6-21, 1929, and that death occurred, on the date stated above, at 4 a m m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) B J Cohen M. D.

6/21, 1929 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Herring Run

DATE OF BURIAL 6/21 1929

20 UNDERTAKER Hof Levinson & Bro

ADDRESS 1127 E Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

E 47034

1—PLACE OF DEATH

REGISTERED NO. E 47034

CITY OF BALTIMORE: (No. 839 S. Montford Ave. ST. 1-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME CATHERINE F. THOMAS

(a) RESIDENCE NO. 839 S. Montford Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

..a If married, widowed, or divorced HUSBAND of (or) WIFE of William S. Thomas

6 DATE OF BIRTH (month, day, and year) February 18, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Columbia
(State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Conrad Lindner

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Not Known

14 Informant Mr. William S. Thomas (Husband)
(Address) 839 S. Montford Ave.

15 Filed ..... 19 ..... C. HAMILTON JONES, M. D. Registrar

N 21525

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19, 1929

17

I HEREBY CERTIFY, That I attended deceased from June 11, 1929 to June 19, 1929;
that I last saw her alive on June 19, 1929.
and that death occurred, on the date stated above, at 9.20 p. m.

The CAUSE OF DEATH* was as follows:

Hypertension and Myocarditis.

From history (since Sept. 1928) (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial failure.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Physical findings.

(Signed) Nathan F. Smith M. D.

. 19 (Address) 7318 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cemetery	June 22, 1929
20 UNDERTAKER Henry Sander & Sons, Inc.	ADDRESS BALTIMORE ST. & BROADWAY.

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47035 HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

E 47035

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 1-2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Peter McFaul

(a) RESIDENCE NO. 3 S. Robinson ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? — yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice McFaul

6 DATE OF BIRTH (month, day, and year) January 4, 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49	5	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Peter McFaul

11 BIRTHPLACE OF FATHER (city or town) (State or country) Irelandi

12 MAIDEN NAME OF MOTHER Rose Mullen

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Records of

(Address) Baltimore City Hosp.

15 Filed JUN 21 1929 E. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 11, 1929, to June 19, 1929, that I last saw h alive on June 19, 1929 and that death occurred, on the date stated above, at 1:00 A. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage of cerebrum, Left, d/t Hemiplegia (recent) not Cardiac

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Same as above (d)

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Home & Here

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Chas

(Signed) Marion Kelly McClean, M. D.

6-19, 1929 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: OAK LAWN CEMETERY — DATE OF BURIAL: June 22, 1929

20 UNDERTAKER: Henry Sander & Sons, Inc. — ADDRESS: BALTIMORE ST. & BROADWAY.

JUN 21 1929

Do not write in pencil, as it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47036

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001

E 47036

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 251 Dallas Ave ST. 1724 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Lucy James

(a) RESIDENCE NO. 251 Dallas Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

important. See instructions on back of certificates. Each statement of OCCUPATION is very

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm A James

6 DATE OF BIRTH (month, day, and year): Feb 22 1873

7 AGE: Years 56 Months 3 Days 25 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Keeper

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Essex Co, Va

PARENTS

10 NAME OF FATHER: Abelson Young

11 BIRTHPLACE OF FATHER (city or town) (State or country): Essex Co, Va

12 MAIDEN NAME OF MOTHER: Rebecca M. Young

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Essex Co, Va

14 Informant: Mrs Jennie Rice

(Address): 1724 Dallas Ave

15 Filed: 21 1929 Dec 19 Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 19. 1929

17 I HEREBY CERTIFY, That I attended deceased from May 21, 1929, to June 19, 1929, that I last saw h[illegible] alive on June 19, 1929 and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cerebral Hemorrhage

(duration) yrs. mos 29 ds.

CONTRIBUTORY (Secondary): Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptomatology

(Signed) A. E. Diddle M. D.

, 19 (Address) 712 N. Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem

DATE OF BURIAL: June 21 29

20 UNDERTAKER: James L Newsley

ADDRESS: 5[illegible] N Eutaw

Cor.—10-10-29—A Co.—100 Bks.

E 47037

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

66 ✓

E 47037
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1101 Thompson St St., 58 Ward)

2-FULL NAME William Ferguson

(a) RESIDENCE NO. 1101 Thompson St St., Ward 8.6
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 4 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
M	B	M

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Carrie Ferguson

6 DATE OF BIRTH (month, day, and year)
1890

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	39			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Bethlehem Steel Co

9 BIRTHPLACE (city or town) Orangeburg
(State or country) S.C.

PARENTS

10 NAME OF FATHER Christopher Ferguson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Irangeburg, S.C.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) S.C.

14 Informant Carrie Ferguson
(Address) 1101 Thompson St

Filed 19 C. HANSON JONES, M. D.
Registrar
By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18, 192 29

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Probably Therapia Conditions contributed (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. C. McCallum, M. D.

6/21/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Edbury County — DATE OF BURIAL 6/21 1929

20 UNDERTAKER Byron Wright — ADDRESS 1219 N. E. Ave

UN 211929

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

Freedly

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44

E 47038

1—PLACE OF DEATH E 47038 REGISTERED NO.

CITY OF BALTIMORE: (No. 325 N. Carrollton Ave. ST., 18-26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Wilhelmina H. Freedly

(a) RESIDENCE NO. 325 N. Carrollton Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 21, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
69	70	11	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Harry Freedly

(Address) 325 N. Carrollton Ave.

15 Filed JUN 21 1929 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20, 1929

17 I HEREBY CERTIFY, That I attended deceased from January 18th 1929, to June 20th, 1929, that I last saw her alive on June 20th, 1929 and that death occurred, on the date stated above, at 12.10 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Liver

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Acidosis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edw. O. Cavalcuer M. D.

. 19 (Address) 2424 W. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cem'	June 22 1929
20 UNDERTAKER Jos. Sefer.	ADDRESS 1600 N. Nor

important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 47039

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 47039

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 804 E. 33rd St. 9-47 WARD)

2-FULL NAME George A Brady

(a) RESIDENCE NO. 804 E 33rd ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Reiley Brady

6 DATE OF BIRTH (month, day, and year) May 28/63

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	66		22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cashier for 604

(b) General nature of industry, business, or establishment in which employed (or employer) Milk distributor

(c) Name of employer Timber Grove Dairy

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER John K. Brady

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Y.

12 MAIDEN NAME OF MOTHER Mary Rumsell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Annie Reiley Brady (Address) 804 E 33rd St

15 Filed JN 21 1929, 19 ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19 1929

17

I HEREBY CERTIFY, That I attended deceased from Dec 29, 1928, to June 19, 1929, that I last saw h alive on June 19, 1929, and that death occurred, on the date stated above, at 10.15 A m.

The CAUSE OF DEATH* was as follows:

Lagrippe followed by Meningitis

(duration) yrs. 6 mos ..... ds.

CONTRIBUTORY (Secondary) Cirrhosis, Emphysema, Coronary thrombosis (duration) yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Spinal tap

(Signed) H. E. Krantz, M. D.

6/20, 1929 (Address) 4025 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. DATE OF BURIAL June 22 1929

20 UNDERTAKER Robt J Turner & Co ADDRESS 1442 N Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

E 47040

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001 V

E 47040

CERTIFICATE OF DEATH

1-PLACE OF DEATH Jenkins Memorial Hospital REGISTERED NO.

City of BALTIMORE: (No. 1000 Caton Ave St., Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth Funk

(a) RESIDENCE NO. 5015 Cordelia Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. (If non-resident give city or town and State)

How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Edward Funk

6 DATE OF BIRTH (month, day, and year): July 6 – 1852

7 AGE: Years 76 Months 11 Days 14 IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER Edward Funk

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Baltimd

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Edward Funk

(Address) 5015 Cordelia Ave

15 Filed ..... C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20 1929

17 I HEREBY CERTIFY, That I attended deceased from April 18, 1929, to June 20, 1929, that I last saw h[illegible] alive on June 19, 1929, and that death occurred, on the date stated above, at 9:05 A m.

The CAUSE OF DEATH* was as follows:

Arteria Sclerosis & Hypertension

Nephritis Chronic

Cerebral Hemorrhage

..... (duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Edema Pneumonia

..... (duration) yrs. mos. 4 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) [illegible], M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem. Date of Burial 6/22 1929

20 UNDERTAKER: Chas. E. Evans & Son ADDRESS 1181 N. Royal Av

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

UN 211029

Spec.—2-29-28—L. F. S.—500 Bks.

E 47041 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47041

REGISTERED NO.

1—PLACE OF DEATH University Hospital

CITY OF BALTIMORE: (No. Balto Md. ST. 4-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Austin Gosnell

(a) RESIDENCE NO. University Hospital ST.. WARD Granite Md.
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. 5 ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 15-1909

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	20		6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Clarence N Gosnell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Estella Peat

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant C N Gosnell

(Address) Granite Md.

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

211920

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 16, 1929, to June 21, 1929, that I last saw h alive on June 21, 1929, and that death occurred, on the date stated above, at 4:30 P m.

The CAUSE OF DEATH* was as follows:

Acute appendicitis

CONTRIBUTORY (Secondary) Peritonitis (duration) yrs. mos. 8 ds.

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of 6-16-29

Was there an autopsy? Yes. 6-20-29

What test confirmed diagnosis? Physical Exam.

(Signed) Lewis P. Tuttle, M. D.

6-21, 1929 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olive Cemetery — DATE OF BURIAL June 22 1929

20 UNDERTAKER Wm Cook — ADDRESS 1217 St Paul.

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47042

CERTIFICATE OF DEATH

133

E 47042

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 146 Montpelier ST. 9-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph C. Houck

(a) RESIDENCE NO. 146 Montpelier ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 14 - 1886

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
43	2	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Philadelphia (State or country)

PARENTS

10 NAME OF FATHER Joseph C. Houck

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Mary A. Knight

13 BIRTHPLACE OF MOTHER (city or town) Camden (State or country) N. J.

14 Informant Mrs Lilly Dyer

(Address) 148 Montpelier St.

15 Filed 7-1-1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20th / 29

17 I HEREBY CERTIFY, That I attended deceased from Nov 15th, 19 28, to June 20th, 19 29, that I last saw h— alive on June 19th, 19 29 and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Pulmonary Congestion

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Streptococcus Infection of Bladder

(duration) yrs. 8 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis Clinical & Lab. Exam

(Signed) Thos. Jungmann M.D. M. D.

6/20/1929 (Address) 481 E 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cem

DATE OF BURIAL 6/22 19 29

20 UNDERTAKER Wm Cook

ADDRESS 1217 Park Ave

important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

E 47043

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-002

E 47043

CERTIFICATE OF DEATH

1-PLACE OF DEATH

REGISTERED NO.

City of BALTIMORE: (No. 4706 Delaware Ave St. 7-56 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie E. Ganley.

(a) RESIDENCE NO. 4706 Delaware Ave St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 Color or Race: W

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: Michael P. Ganley

6 DATE OF BIRTH (month, day, and year): Oct 8-1869

7 AGE: Years 59 Months 7 Days 11

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Balt

(State or country)

PARENTS

10 NAME OF FATHER: Michael Dunn

11 BIRTHPLACE OF FATHER (City or town):

(State or country): Ireland

12 MAIDEN NAME OF MOTHER: Annie Redmond

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Virginia

14 Informant: Mrs E Ganley

(Address): 4706 Delaware Ave

15 Filed ..... 1929 By ..... Registrar

FRAMPSON JONES

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 1929 June 19

17 I HEREBY CERTIFY, That I attended deceased from July 3, 1927, to June 19, 1929,

that I last saw her alive on June 19, 1929,

and that death occurred, on the date stated above, at 11.30 P m

The CAUSE OF DEATH* was as follows:

Cerebral Arteriosclerosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? NO Date of

Was there an autopsy? NO

What test confirmed diagnosis? Clinical Signs & Symptoms

(Signed) K. B. Boyd M. D.

19 (Address) 1619 Park Heights Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
New Cathedral Cem	6/22 1929
20 UNDERTAKER J. J. Moran	ADDRESS 300 E. Baltimore St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JUL 21 1929

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47044

CERTIFICATE OF DEATH

47

E 47044

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) 3113 E. Inc (St.) Eldersly (WARD) 47

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Grace In. Tyler

(a) RESIDENCE NO. 3113 E Inc Eldersly WARD

(Usual place of abode)

Length of residence in city or town where death occurred 53 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F. 4 COLOR OR RACE W. 5 Single, Married, Widowed, or Divorced, (write the word) Married

a If married, widowed, or divorced (or) WIFE of Theadore Tyler

6 DATE OF BIRTH (month, day, and year) Oct 8 1875

7 AGE Years 53 Months 7 Days 10 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Joseph Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) City

12 MAIDEN NAME OF MOTHER Margaret Bagnell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) City

14 Informant Estelle Tyler

(Address) 3113 E Inc Eldersly

15 Filed 1929 C. HAMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19/29

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1929, to June 19, 1929.

that I last saw h alive on " " 1929

and that death occurred, on the date stated above, at 6.24 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Brest & Lungs

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Bright's Kidney Disease (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of June 11/29

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) W. C. Hems M. D.

(Add.) 3901 Fairview Blvd

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Hs Redeemer Cem	June 22 1929
20 UNDERTAKER J. F. Moran	ADDRESS 3?? E Baltimore

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47045

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47045

129

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 217 W. Lorraine Ave. ST. 12-51 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Barbara Hucht

(a) RESIDENCE NO. 217 W. Lorraine Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) Sept. 8, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	9	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Bernard Hucht

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Mary E. Geis

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant William E. Bauer

(Address) 10 S. Calvert St.

15 21929 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 20, 1926 to June 19 1929.

that I last saw h— alive on June 18 1929.

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Cardio-vascular renal disease
With Hypertension

(duration) 9 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? B.P. Urinalysis

(Signed) Howard M Bubert, M. D.

6/20 1929 (Address) Med. Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 6/22 1929

20 UNDERTAKER Henry U. Mears & Son

ADDRESS 805 N. Calvert

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 47046

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 47046

32

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hosp. ST. 7129 WARD)

2-FULL NAME John Bisesi

(a) RESIDENCE NO. 1207 Denver ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 15 1924

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
4	10	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John E Bisesi

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Marie Boundley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant John E Bisesi

(Address) 1207 Denver St

15 C. HAMPSON JONES, M. D.

Registrar

211929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/21 1929

17 I HEREBY CERTIFY, That I attended deceased from 6/15 1929, to 6/21 1929,

that I last saw h/ alive on 6/21 1929,

and that death occurred, on the date stated above, at 3:00 Am.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) yrs. ..... mos 16 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of —

Was there an autopsy? Yes —

What test confirmed diagnosis? Physical Exam,

(Signed) H. A. Silver, M. D.

(Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: 6/24/29

20 UNDERTAKER: Harry A Wilkes — ADDRESS: 5310 Loudon St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47047 HEALTH DEPARTMENT—CITY OF BALTIMORE 92 E 47047

CERTIFICATE OF DEATH

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No.) Balt. City Hosp ST. 14-28 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Grey

(a) RESIDENCE NO. 218 S. Fulton Ave. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Mal.	Whit.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ? Grey

6 DATE OF BIRTH (month, day, and year) March 7, 1852 Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	3	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None old

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Harry Grey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Record

(Address)

15 Filed 2 1929, 19 Per C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/20/29

17 I HEREBY CERTIFY, That I attended deceased from 6/17, 1929, to 6/20, 1929, that I last saw him alive on 6/20, 1929, and that death occurred, on the date stated above, at 10 a.m.

The CAUSE OF DEATH* was as follows:

Arterial thrombosis of left leg with gangrene.

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Post operative shock-Myocarditis (duration) yrs. mos. ½ hr.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 6/20/29

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. U. Liemphein, M. D.

6/20, 1929 (Address) Balt. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	June 22 1929

20 UNDERTAKER Harry F. Wittke, 531 N. Lombard St. ADDRESS

important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 47048 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47048

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital (St.) 25-72 (WARD) 161-008

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Girl Varetto

(a) RESIDENCE NO. Hall & Hopkins Ave (ST.) Sandtown (WARD)

(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 20, 1929

7 AGE: Years ... Months ... Days ... If LESS than 1 day, 6 hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: John Varetto

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Mable Baldwin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: John Varetto (Address) Hall & Hopkins Ave

15 Filed ... 19 ... HAMPSON JONES, M. D. Registrar

21 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6 - 20 1929

17 I HEREBY CERTIFY, That I attended deceased from 6-20, 1929, to 6-20, 1929

that I last saw her alive on 6-20, 1929

and that death occurred, on the date stated above, at 11.00 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ... yrs. 7½ mos ... ds.

CONTRIBUTORY (Secondary) Placenta Previa

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? ... Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dudley P. Bowe, M. D.

6-21, 1929 (Address) 904 N. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: June 21 1929

20 UNDERTAKER: Harry A. Witzke — ADDRESS: 153 W. Lombard

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47049

E 47049

CERTIFICATE OF DEATH

1—PLACE OF DEATH St. Josephs Hospital REGISTERED NO. 27-47

CITY OF BALTIMORE: (No. Francis Scott Key Dengo ST. 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Boy Dengo

(a) RESIDENCE NO. 2723 Overland Ave WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 17 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Leonard Dengo

11 BIRTHPLACE OF FATHER (city or town) Estonia (State or country)

12 MAIDEN NAME OF MOTHER Sarah Mae Arnold

13 BIRTHPLACE OF MOTHER (city or town) New London (State or country)

14 Informant Mr Leonard Dengo

(Address) 2723 Overland Ave

Filed JUN 21 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 1929

17 I HEREBY CERTIFY, That I attended deceased from 6-17-29, 19, to 6-21-29, 19, that I last saw h. alive on 6-21-29, 19, and that death occurred, on the date stated above, at 2:10 P. m.

The CAUSE OF DEATH* was as follows:

Anuria

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) O. C. Zimmerman, M. D.

, 19 (Address) St. Josephs Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	June 23 1929
20 UNDERTAKER	ADDRESS
Henry Worrell & Sons Inc.	120 E Eager St

Important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47050

CERTIFICATE OF DEATH.

E 47050

1-PLACE OF DEATH

City of BALTIMORE: (No. W. Balto Gen Hos. St.) (Ward) REGISTERED NO.

2-FULL NAME Clarence W. Donnelly

(a) RESIDENCE 3407 Chestnut Ave St. Ward

(Usual place of abode)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of): Jessie E. Donnelly

6 DATE OF BIRTH (month, day, and year): Apr. 20-1893

7 AGE: Years 36 Months 2 Days

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Ry Employ

(b) General nature of industry, business, or establishment in which employed (or employer): Pa. Ry

(c) Name of employer

9 BIRTHPLACE (city or town): Balto City

(State or country)

PARENTS

10 NAME OF FATHER: Frank. Donnelly

11 BIRTHPLACE OF FATHER (city or town): Balto. Co.

(State or country)

12 MAIDEN NAME OF MOTHER: Elizabeth Boulden

13 BIRTHPLACE OF MOTHER (city or town): Md

(State or country)

14 Informant: Mrs Jessie E. Donnelly

(Address) 3407 Chestnut Ave

Filed 1929 C. HAMPSON JONES, M. D. Registrar

211929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): Jan 19 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows: Accident. Fell off freight Car Sevre Lacerations & Contusions R. Thigh (duration) Yrs. Mos. Ds. 12 hours

CONTRIBUTORY (Secondary) Shock. (duration) Yrs. Mos. Ds.

Jan 20th (Date) F. B. Link (Coroner) M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death? La Fayette Ave & P. R. R.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Date of Burial Jan 22 1929

20 UNDERTAKER: W. H. Marshall ADDRESS 3539 Fells Roo

If non-resident give city or town and State should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 47051 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47051

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hosp ST. 24-35 WARD)

2-FULL NAME Margaret Krick

(a) RESIDENCE NO. 1411 Cookie ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Femal

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant

6 DATE OF BIRTH (month, day, and year): Feb 23 1929

7 AGE: Years — Months: 3 — Days: 29 — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Nicholas Krick

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Elizabeth Kovacs

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): Mrs Elizabeth Krick 1417 Lanvale

15 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/21 1929

17 I HEREBY CERTIFY, That I attended deceased from 6/17/29, to 6/21/29, that I last saw her alive on 6/21/29, and that death occurred, on the date stated above, at 3:50 Am.

The CAUSE OF DEATH* was as follows:

1 Malnutrition.

2 Broncho-pneum - at home.

(duration) yrs. (2) (1) mos (5) (2) ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis? Typical Exam.

(Signed) A. H. Gilmour, M. D.

, 19 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross C. A. Cortlet

DATE OF BURIAL: June 22 1929

20 UNDERTAKER: F. A. Kemp

ADDRESS: 4507 Park Ave

211929

HEALTH DEPARTMENT should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 47052

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

14-001

E 47052

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2108 Barclay St., 12-50 Ward)

2-FULL NAME Lewis W. Scherer

(a) RESIDENCE NO. 2108 Barclay St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 11 mos. 1 ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ------

6 DATE OF BIRTH (month, day, and year) July 19, 1865

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	63	11	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Carpenter
(b) General nature of industry, business, or establishment in which employed (or employer) Walsh Construction
(c) Name of employer Company

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER William C. Scherer

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary J. Gardner

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Miss Clara P. Scherer
(Address) 2108 Barclay Street

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

JUN 21 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-20 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest, autopsy or inquiry find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Jno. Thomsen, M. D.

6/21, 1929 (Address) 3602 Roland Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	6/24 1929

20 UNDERTAKER Henry W. Spears & Son ADDRESS 50 W. Calvert

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 47053 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92 E 47053

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. St Agnes Hosp St. 12-50 WARD)

2-FULL NAME Charles Gordon Collenberg.

(a) RESIDENCE No. 3101 Guilford Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 27, 1881

7 AGE Years 47 Months 0 Days 27 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Collector

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Dr J. H Collenberg

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)

12 MAIDEN NAME OF MOTHER Mary J Hodges

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Mrs Mary J Collenberg (Address) 3101 Guilford ave

15 Filed , 19 C. HAMPSON JONES, M. D. Registrar

N 21929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20 19 29

17

I HEREBY CERTIFY, That I attended deceased from June 17, 19 29 to June 20, 19 29, that I last saw h alive on June 20, 19 29, and that death occurred, on the date stated above, at 10 25 a.m.

The CAUSE OF DEATH* was as follows:

Brain Abscess (rt frontal)

Staphylococcus Salphaccoeminolarens

(duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary) Embolism (respiratory center)

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at his home.

Did an operation precede death? yes Date of June 17, 1929

Was there an autopsy? no

What test confirmed diagnosis? Operation & Laboratory

(Signed) Nicholas P Borelli, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery

DATE OF BURIAL June 22 1929

20 UNDERTAKER John Allred

ADDRESS 200 Orleans

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47054

CERTIFICATE OF DEATH

E 47054

74-99

1-PLACE OF DEATH

City of Baltimore: (No. 815 E. Fort Ave. St. 24-34 Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George H. Conway.

(a) RESIDENCE NO. 815 E. Fort Ave. St., Ward .....

(Usual place of abode)

Length of residence in city or town where death occurred 73 yrs. 7 mos. 5 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) November 12, 1855

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	73	7	5	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer) .....
(c) Name of employer .....

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Samuel Conway.

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Sarah Phillips.

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) England.

14 Informant Emma J. B. Neveker. (sister)
(Address) 815 E. Fort Ave.

15 Filed ....., 19.. C. HAMPSON JONES, M. D.
Registrar

N 211929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) June 19, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.
Hemiplegia.
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? .....
Did an operation precede death? No. Date of .....
Was there an autopsy? No.
What test confirmed diagnosis? Inquiry.

(Signed) C. Earl Stennard M. D.
6/20. 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cem. DATE OF BURIAL June 22 1929

20 UNDERTAKER Margard & Flynn ADDRESS 1422 Light St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

Cut 5912 Pulaski Hwy

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47055

CERTIFICATE OF DEATH

E 47055

REGISTERED NO. 21115

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 5425 Ruxton Rd ST. 27th WARD)

2—FULL NAME Emma Rosella Gerber

(a) RESIDENCE NO. 5425 Ruxton Road WARD
(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Henry

6 DATE OF BIRTH (month, day, and year): June 16 1878

7 AGE: Years 31 Months Days 2 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Penn.

PARENTS

10 NAME OF FATHER: Benjamin Butler

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Rosella Parks

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Emma Gerber
(Address) 5425 Ruxton Rd

15 Filed JUN 21 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 18 1929

17 I HEREBY CERTIFY That I attended deceased from June 17 1929 to June 18 1929, that I last saw h[er] alive on June 18 1929 and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Post Abortum Sepsis.

Dyd. Coroner J. J. Thomassey

(duration) yrs. 1 mos. 14 ds.

CONTRIBUTORY (Secondary): Hypostatic Pneumonia

(duration) yrs. 1 mos. d[s]

18 Where was disease contracted if not at place of death? Mrs. Roberts

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) T. H. Collins M. D.

19 (Address) 5912 Pulaski Highway Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Mary's Hampden

DATE OF BURIAL: June 22 1929

20 UNDERTAKER: H. M. Cole

ADDRESS: 1217 St Paul

IN 21 1929

Of DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS is very important. See instructions on back of certificates.

HEALTH DEPARTMENT--CITY OF BALTIMORE

E 47056

1 PLACE OF DEATH

CERTIFICATE OF DEATH

75-807

E 47056

REGISTERED No. C

CITY OF BALTIMORE (No. 2004 Homewood Ave St.) (If death occured in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME John B. Langley

(Residence in Baltimore: No. 2004 Homewood Ave Ward)

St.: 72 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word): Married

6 DATE OF BIRTH: March 15, 1857 (Month) (Day) (Year)

7 AGE: 72 yrs. 3 mos. 2 ds. If LESS than 1 day, hrs. or min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: R R Foreman
(b) General nature of industry, business, or establishment in which employed (or employer): Penn. R R Co

9 BIRTHPLACE (State or country): Md.

PARENTS

10 NAME OF FATHER: Benj. F. Langley

11 BIRTHPLACE OF FATHER (State or country): Balto.

12 MAIDEN NAME OF MOTHER: Elizabeth Bowman

13 BIRTHPLACE OF MOTHER (State or country): Penn

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John B. Langley

(Address) 2004 Homewood Ave

15. 21 1929, 191 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: June 21, 1929 (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from Apr. 1928. to June 20 1929

that I saw h-m alive on June 21 1929

and that death occurred, on the date stated above, at 8.15 P. m.

The CAUSE OF DEATH* was as follows:

Paralysis - "paraplegia"

(Duration) 1 yrs. 2 mos. — ds

Contributory (SECONDARY)

(Duration) yrs. mos. ds.

(Signed) H. G. Prentiss M. D.

June 21 1929 (Address) 631 Gorsuch Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death: yrs. mos. ds. In the State: yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL: Loudon Park | DATE OF BURIAL: June 24 1929

20 UNDERTAKER: Wm Cook | ADDRESS: 12 75 E Pratt

1. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47057

CERTIFICATE OF DEATH

49 E 47057

1—PLACE OF DEATH

REGISTERED NO. 12-50

CITY OF BALTIMORE: (No. 3133 Abell Av. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Nicholas Homand

(a) RESIDENCE NO. 3133 Abell Av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. 0 mos. 0 ds. How long in U. S., if foreign birth? 25 yrs. 0 mos. 0 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Emily A. Homand.

6 DATE OF BIRTH (month, day, and year) Sept-14-1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	9	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stationary Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) City of Baltimore

(c) Name of employer

9 BIRTHPLACE (city or town) Eprios

(State or country) Greece

PARENTS

10 NAME OF FATHER Spiro Homand

11 BIRTHPLACE OF FATHER (city or town) Eprios

(State or country) Greece

12 MAIDEN NAME OF MOTHER Anna Dunos

13 BIRTHPLACE OF MOTHER (city or town) Eprios

(State or country) Greece

14 Informant Mrs Emily A. Homand (wife)

(Address) 3133 Abell Av city

15 Filed 1929 C. HAMPSON JONES, M. D. Registrar

211929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 13, 1929, to June 21, 1929, that I last saw h alive on June 20, 1929 and that death occurred, on the date stated above, at 4.30 A. m.

The CAUSE OF DEATH* was as follows:

Cancer Primary - metastases in lung & mediastinum

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Removal of piece of growth for examination

(Signed) Harry A. McCarty, M. D.

6-21, 1929 (Address) 37 N Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	June 24, 1929
20 UNDERTAKER	ADDRESS
Edward H. Mowen Company	Balto.

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47058

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

3/ E 47058

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Baltimore City Hospitals (ST.) (T. B.) (WARD) 17 Mo

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Hattie Brockman

(a) RESIDENCE NO. 726½ W. Franklin st. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Brockman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records (Address)

15 Filed ..., 19... C. HAMPSON JONES, M. D. Registrar

N 22[illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept. 29, 1928, to June 20, 1929, that I last saw her alive on June 20, 1929 and that death occurred, on the date stated above, at 9 p. m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical and lab.

(Signed) Henry C. Smith, M. D.

6-21 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	June 24 1929

20 UNDERTAKER Samuel H. Hensley ADDRESS 1[illegible]

Important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 47059 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47059

CERTIFICATE OF DEATH.

46

1-PLACE OF DEATH

CITY OF BALTIMORE, (No.) 1803 Lorman ST. 16-22 (WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Pearl Jackson Jones

(a) RESIDENCE NO. 1803 Lorman ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 31 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Col.	Married

5a If married, widowed, or divorced
(or) WIFE of Norman Jones

6 DATE OF BIRTH (month, day, and year) Nov 11, 1897

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
31	7	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer) ~~0~~ none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Andrew Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mary Noel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Helen Gross (sister)
(Address) 1624 N. Mount St

15 Filed ..... 19 ..... HAMPSON JONES M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-21- 19 29

17 I HEREBY CERTIFY, That I attended deceased from 5/29 .19 29. to 6/21 .19 29. that I last saw her alive on 6/20 .19 29. and that death occurred, on the date stated above, at 7.30 A m.

The CAUSE OF DEATH* was as follows:
Carcinoma Uteri

(duration) ..... yrs. 1½ mos ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Ordinary

(Signed) Wm H. Frazier M. D.

. 19 (Address) 138 W. Hoffman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn DATE OF BURIAL June 24 1929

20 UNDERTAKER Virginia A Brooks ADDRESS 1463 N. Carey

TION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47060

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

78 E 47060

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 1611 Millman ST. 7-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ruth Victoria Green

(a) RESIDENCE NO. 1611 Millman ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, Divorced, (write the word)
Female	Colored	Divorced

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 31-1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34		18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) Lochraven
(State or country) Balto. Co. Md.

PARENTS

10 NAME OF FATHER John C. Green.

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Jennie Smith.

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Jennie Green.
(Address) 1611 Millman St.

15 Filed ....., 19 .....
C. HAMPSON JONES, M. D.
Registrar

221929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 19-1929

17 I HEREBY CERTIFY, That I attended deceased from June 7, 1929, to June 19, 1929, that I last saw h[illegible] alive on June 19, 1929, and that death occurred, on the date stated above, at 5-30 a. m.

The CAUSE OF DEATH* was as follows:

Epilepsy

Several yrs (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart failure

Bronchitis (duration) 2 yrs. 2 mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. Edward Fisher M. D.

6-20 1929 (Address) 1612 Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laurel Cemetery	June 22 1929
20 UNDERTAKER	ADDRESS
Chas. H. Johnson	416 N. Carolina St.

important. See instructions on back of certificates.

Spec. 6-3-19—H. P. Co.—1000 Blks.

E 47061 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47061

CERTIFICATE OF DEATH.

74-201

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 1112 Russell St. 71-31 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Cressie Sampson

(a) RESIDENCE. NO. 1112 Russell St. ST., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. 4 mos. 4 ds. How long in U. S., if of foreign birth? 63 yrs. 4 mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank Sampson

6 DATE OF BIRTH (month, day, and year): May 25 1876

7 AGE — Years: 53 — Months: — Days: 24 — If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Hairdresser

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: William Watts

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Lenhurn

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Frank Sampson 1112 Russell St

15 [illegible] 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): Jan 19 1929

17 I HEREBY CERTIFY, That I attended deceased from June 12, 1929, to Jan 19, 1929, that I last saw him alive on Jan 19, 1929, and that death occurred, on the date stated above, at 0 P — m.

The CAUSE OF DEATH* was as follows:

Pneumonia Contributory Hemorrhage

(duration) yrs. — mos. 7 ds.

CONTRIBUTORY (Secondary): Anaemia

(duration) yrs. — mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Characteristic symptoms

(Signed) Frank N. Flowers, M. D.

(Address) 712 E. Biddle St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Zion Ct — DATE OF BURIAL: June 23 1929

20 UNDERTAKER: A. E. Brown & Son — ADDRESS: 1010 Mond

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

221929

C. HAMPSON JONES, M. D.

Spec.—2-29-28—L. F. S.—500 Bks.

Interment June 24 1929

E 47062

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47062

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital WARD 9-45

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

REGISTERED NO.

2—FULL NAME JOHN MACK

(a) RESIDENCE NO. Reisterstown, ST. Md WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 3 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 1, 1927

7 AGE — Years: 1 | Months: 10 | Days: 20 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Reisterstown Md

PARENTS

10 NAME OF FATHER: John Mack

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Agnes Roberson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Agnes Mack

(Address): Reisterstown Md

15 Filed 6-22 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 19, 1929, to June 21, 1929, that I last saw h[illegible]ive on June 21, 1929 and that death occurred, on the date stated above, at 10 15 p m.

The CAUSE OF DEATH* was as follows:

Pertussis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary): Broncho-pneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Reisterstown, Md

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings + X ray

(Signed) Addison Craft Sydenham Hospital, M. D.

6-22 1929 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Lucas Cemetery	June 24 1929
20 UNDERTAKER	ADDRESS
H F Clare	Reisterstown Md

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47063

CERTIFICATE OF DEATH

E 47063

REGISTERED NO. 1681

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 630 Franklintown Rd.) (Ward) 17-25

2-FULL NAME Eugene V. Von Newendorf.

(a) RESIDENCE NO. 630 N. Franklintown Rd. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence Orr.

6 DATE OF BIRTH (month, day, and year) Nov 8—1885

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	43	7	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Storekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Germany
(State or country)

PARENTS

10 NAME OF FATHER Chas C. Von Newendorf

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Florence V. Von Newendorf
(Address) 630 N. Franklintown Rd.

15 Filed ..... 19.. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Suicide
Strangulation due to hanging self (duration) yrs. Sudden.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) June 21 '29 Reginald Adelbert Coroner, M. D.
(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER Geo W Linde — ADDRESS

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

22 1929

Spec.—1-10-21—M&T—1500 Bks.

E 47064 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47064

CERTIFICATE OF DEATH. 146

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 5-9 WARD)

2-FULL NAME Lilly Cornish Elliott

(a) RESIDENCE No. 1409 Orleans St ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1906

7 AGE: Years 23; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: N H 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Robt Elliot

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Martha Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUN 22 1929 C. HAMPSON JONES, M. D. Registrar

By ..... RPH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 20 1929

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1929, to June 20, 1929, that I last saw h[illegible] alive on June, 1929, and that death occurred, on the date stated above, at 1140 A m.

The CAUSE OF DEATH* was as follows:

(1) Enteritis, pelvis and abdominal

(2) Tubo-ovarian Abscess left

(duration) — yrs. — mos. 2-4 ds.

CONTRIBUTORY (Secondary) Endangitis? 2-14 mos

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? ...

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) H. G. Schloss M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cemetery Md — DATE OF BURIAL: June 22 1929

20 UNDERTAKER: Robt I Williams & Son — ADDRESS: 15 McCulloh St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

925
22 E 47065

CERTIFICATE OF DEATH.

37-E 47065

REGISTERED NO. .....

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 5-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E Wilson

(a) RESIDENCE NO. 911 N Eden ST., ... WARD .....
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
female	black	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	5			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) .....

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) .....

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 [illegible] 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 16 1929

17 I HEREBY CERTIFY, That I attended deceased from June 3 . 1929 . to June 16 . 1929 .
that I last saw h[illegible] alive on June 16 . 1929 .
and that death occurred, on the date stated above, at 4 45 P m.
The CAUSE OF DEATH* was as follows:
1 Cer. Meningitis

(duration) ..... yrs. ..... mos. 10 ds.

CONTRIBUTORY (Secondary) Miliary Tc

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? .....

(Signed) W. C. Goodwin, M. D.

6/17, 1929 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL ..... DATE OF BURIAL 19

20 UNDERTAKER ..... ADDRESS .....

JUN 2 1929

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47066

CERTIFICATE OF DEATH.

E 47066

153

REGISTERED NO. 26-37

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. WARD)

2-FULL NAME Edna Perry

(a) RESIDENCE NO. 3738 Bank ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word):

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years | Months | Days 1 week | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Wm E. Perry

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Records (Address)

15 Filed 6 22 1929 C. HAMPSON JONES, M. D. By Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/20 1929

17 I HEREBY CERTIFY, That I attended deceased from 6/19 1929 to 6/20 1929,

that I last saw her alive on 6/20 1929,

and that death occurred, on the date stated above, at 3:20 A m.

The CAUSE OF DEATH* was as follows:

1. Suppurative Peritonitis

2 Pelvic Abscess

(duration) yrs. mos ~ ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 6/17/29

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) A. C. Goodwin, M. D.

6/22, 1929 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

JUN 22 1929

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 47067 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47067

CERTIFICATE OF DEATH.

114

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1319 W. Lombard ST. 14-29 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Nothe, Jr.

(a) RESIDENCE NO. 1319 W. Lombard, ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Feb. 27 - 1927

7 AGE — Years: 2 — Months: 3 — Days: 23 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Frank H. Nothe

11 BIRTHPLACE OF FATHER (city or town) (State or country): Phila. Pa.

12 MAIDEN NAME OF MOTHER: Grace Fi[illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant (Address): Frank Nothe

15 Filed 19 Registrar

C. HAMPSON JONES, M. D.

221578

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 20 1929

17

I HEREBY CERTIFY, That I attended deceased from June 19, 1929, to June 20, 1929, that I last saw h[illegible] alive on June 20, 1929, and that death occurred, on the date stated above, at 12 45 p. m.

The CAUSE OF DEATH* was as follows:

Entero-colitis

(duration) yrs. mos 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical findings

(Signed) A. Bachmeyer M. D.

6/21, 1929 (Address) 37 E. Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — DATE OF BURIAL: 6/24 1929

20 UNDERTAKER: Fredk A. Cole — ADDRESS: 1616 N Bdwy

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 47068

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47068

CERTIFICATE OF DEATH.

337

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 415 N. Durham ST. 6-9 WARD)

2-FULL NAME Mary Scott

(a) RESIDENCE NO. 415 N. Durham ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colord	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ronie Scott

6 DATE OF BIRTH (month, day, and year) Oct 1st 1904

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	24	9	8	

8 OCCUPATION OF DECEASED House Wife

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) S.C

PARENTS

10 NAME OF FATHER Jim Bright

11 BIRTHPLACE OF FATHER (city or town) (State or country) S.C

12 MAIDEN NAME OF MOTHER Julie Gray

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S.C

14 Informant Ronie Scott

(Address) 415 N. Durham St

15 6/21/1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20, 1929.

17 I HEREBY CERTIFY, That I attended deceased from May 16, 1929, to June 20, 1929.

that I last saw h[illegible] alive on June 16, 1929

and that death occurred, on the date stated above, at 4.30 a. m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Intestines.

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no.

What test confirmed diagnosis? Microscope

(Signed) C. H. P. Scott, M. D.

6/21/1929 (Address) 1536 W. Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury cemetery — DATE OF BURIAL June 24 1929

20 UNDERTAKER Edward Bryan — ADDRESS 1631 Orleans St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47069 E 47069

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1424 Bank ST. 3-4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Johnson

(a) RESIDENCE No. 1424 Bank ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colord	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Henry Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Henrietta Morris

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Henrietta Perry

(Address) 1494 Bank St

15 19 Registrar

221029

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22 1929

17 I HEREBY CERTIFY That I attended deceased from June 1, 1929, to June 21, 1929, that I last saw h[illegible] alive on June 21, 1929 and that death occurred, on the date stated above, at 4.30 A m

The CAUSE OF DEATH* was as follows:

acute nephritis

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Cardiac Decompensation

(duration) yrs. mos. ds.

over

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Leland S Easlup M. D

19 (Address) 1516 E Baltimore St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury cemetery

DATE OF BURIAL June 26 1929

20 UNDERTAKER Edward Bryon

ADDRESS 1631 Orleans St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 47070

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

× 24

E 47070

1-PLACE OF DEATH

REGISTERED NO. 70-76

CITY OF BALTIMORE: (No.) St Agnes Hospital ST. (or) WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Raymond Tornell

(a) RESIDENCE No. 711 Beaumont Av ST., Catonsville Md WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) — — 1915

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	14			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Michael Tornell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Perrod

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Tornell

(Address) 711 Beaumont Av

15 Filed , 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 19 29

17 I HEREBY CERTIFY, That I attended deceased from June 19, 1929, to June 21, 1929, that I last saw h[illegible] alive on June 21, 1929 and that death occurred, on the date stated above, at 6 45 m.

The CAUSE OF DEATH* was as follows:

Ap. Cerebro-spinal meningitis

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Typical spinal fluid

(Signed) W. A. Tuck, M. D.

June, 19 29 (Address) 420 Ford Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Md Medical Coll DATE OF BURIAL 6/27/29

20 UNDERTAKER John F Tobey Sons ADDRESS 731 Edgar St.

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

326303

E 47071

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

135

E 47071

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. 11-21 (WARD)

2-FULL NAME Dowling Brown

(a) RESIDENCE NO. 224 W. Chase ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: black

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E

6 DATE OF BIRTH (month, day, and year) 1876

7 AGE — Years: 53 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Janitor

(b) General nature of industry, business, or establishment in which employed (or employer): 0/0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER Charles Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER Sarah Madden

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed .19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 19 29

17 I HEREBY CERTIFY, That I attended deceased from June 15. 19 29. to June 21. 19 29.

that I last saw h[illegible] alive on June 21 . 19 29.

and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

[illegible] [illegible]

[illegible]

Benign Prostatic Hypertrophy

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Embolus

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) [illegible] M. D.

. 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL 6-23 1929

20 UNDERTAKER Daniel Easter — ADDRESS 916 [illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47072

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47072

CERTIFICATE OF DEATH

31 E[redacted]

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST. 8.B. 16-26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Hattie Goode

(a) RESIDENCE NO. 917 W. Lexington st. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1912

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	17			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Sanders Goode

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Lulu Henry

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records

(Address)

15 Filed [illegible], 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21, 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov. 7, 1928, to June 21, 1929, that I last saw her alive on June 21, 1929 and that death occurred, on the date stated above, at 11.50 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical and lab.

(Signed) Henry Smith, M. D.

6-21, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
[illegible]	6-23 1929
20 UNDERTAKER	ADDRESS
[illegible]	[illegible]

Important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

E47073 · HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 47073
REGISTERED NO. C

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Gundry Sanatorium Fred[illegible] WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Minnie Garnett Hodgson

(Residence in Baltimore: No. Gundry Sanitarium Falls Road City St.: 27 yrs. mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX.	4-COLOR OR RACE,	5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)
Female	White	Married

6-DATE OF BIRTH, Dec. (Month) 2 (Day), 1849 (Year)

7-AGE, 72 yrs. 6 mos. 17 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work: Home work
(b) General nature of industry, business, or establishment in which employed (or employer):

9-BIRTHPLACE, (State or Country), Virginia

PARENTS.

10-NAME OF FATHER, Thomas Gordon

11-BIRTHPLACE OF FATHER (State or Country), Virginia

12-MAIDEN NAME OF MOTHER Susanna M Jones

13-BIRTHPLACE OF MOTHER (State or Country), Virginia

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Gundry Sanatorium

(Address)

15- JUN 23 1922, 191[illegible] [illegible] JONES, M. D.
Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 22 (Day), 1922 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 20 1922, to June 22 1922, that I saw h[illegible] alive on June 22 1922, and that death occurred, on the date stated above, at 10-20 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(Duration) yrs. Two mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) yrs. mos. 10 ds.

(Signed) Stephen J. Ramsay M. D.

, 191... (Address) Gaithersburg Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 27 yrs. 5 mos. ds. In the State 27 yrs. 5 mos. ds.

Where was disease contracted, if not at place of death? Hallowchuck Va

Former or usual residence " " "

19-PLACE OF BURIAL OR REMOVAL, Rockville Md — DATE OF BURIAL, 6/24, 1922

20-UNDERTAKER W. B. Humphrey & Son — ADDRESS Rockville Md.

Important. See instructions on back of certificate.

Spec.—7-17-26—A Co.—200 Blks.

E 47074

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47074
REGISTERED NO.

1-PLACE OF DEATH Maryland General Hosp. 100-001

City of BALTIMORE: (No. Howard + Madison St 11-25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Clarence W Ensor

(a) RESIDENCE NO. Beckleysville, Md St. Ward
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 2 ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 20, 1926

7 AGE: Years 3 Months 1 Days 2 IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Beckleysville
(State or country) Md

PARENTS

10 NAME OF FATHER Harry Ensor

11 BIRTHPLACE OF FATHER (City or town) Butler
(State or country) Md

12 MAIDEN NAME OF MOTHER Ella Roach

13 BIRTHPLACE OF MOTHER (city or town) Parkton
(State or country) Md

14 Informant Hosp. Record
(Address)

JUN 23 1929

C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22 1929

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1929, to June 22, 1929, that I last saw him alive on June 22, 1929, and that death occurred, on the date stated above, at 4.30 Am.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Empyema

(duration) yrs. mos. ? ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of June 21

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) H. K. Kopelmeier, M. D.

6/22, 1929 (Address) Md Gen Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Middletown Md Balto Co. Date of Burial June 24 1929

20 UNDERTAKER E. Le Roy Stufflebeam ADDRESS 1952 North Ave

This should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Pinerman

E 47075 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47075

CERTIFICATE OF DEATH.

REGISTERED NO. 57

1-PLACE OF DEATH Sinai Hospital Baltimore

If death occurred in a hospital or institution, give its NAME instead of street and number.

CITY OF BALTIMORE: (No. 58 ST.) (WARD) OR County

2-FULL NAME Moses Pinerman

(a) RESIDENCE No. 1024 E. Fayette ST. WARD 6/17

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah

6 DATE OF BIRTH (month, day, and year) 1875

7 AGE: Years 54; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Merchant

(b) General nature of industry, business, or establishment in which employed (or employer): O H S

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Crimea

PARENTS

10 NAME OF FATHER Jerome Pinerman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Mrs S. Pinerman

(Address) 1024 E Fayette St

Filed JUN 3 1929 19 C. MARSHALL JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1929 to June 20, 1929

that I last saw him alive on 10:20 P.M. June 20, 1929

and that death occurred, on the date stated above, at 10:20 m.

The CAUSE OF DEATH* was as follows:

Coronary failure associated with Cerebral Thrombosis — upon a Diabetic arteriosclerosis

(duration) yrs. 1 mos 15 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Hamil Cho M. D.

6/21 1929 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Herring Run

DATE OF BURIAL: June 23 1929

20 UNDERTAKER: Sol Levinson & Bro

ADDRESS 1127 E Balto St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47076 ✓ E 47076

CERTIFICATE OF DEATH

47

1—PLACE OF DEATH

REGISTERED NO. 13-59

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 940 Whitelock St ST. WARD)

2—FULL NAME Rebecca Smith

(a) RESIDENCE NO. 940 Whitelock St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1903

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seet

(b) General nature of industry, business, or establishment in which employed (or employer) Confection

(c) Name of employer Kimmel

9 BIRTHPLACE (city or town) (State or country) Balto City Md

PARENTS

10 NAME OF FATHER Herman Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Mary Sacks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

11 Informant P. Sacks

(Address) 940 Whitelock St

15 Filed 19 H. HAMILTON JONES, M. D. Registrar

231529

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/21/29

17 I HEREBY CERTIFY, That I attended deceased from June, 19 29, to June 21, 19 29, that I last saw her alive on June 21, 19 29 and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows: Myocardial failure Carcinoma Duodenum

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Carcinoma of Breast

(duration) 2 yrs 4 mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 3/14/28

Was there an autopsy? No

What test confirmed diagnosis? Pathologic exam of Breast

(Signed) Louis Sacks M. D.

6/22 19 29 (Address) 940 Whitelock St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rehrer Hebrew Cem

DATE OF BURIAL 6/23 19 29

20 UNDERTAKER Jack Levis

ADDRESS 1439 Walbrook

Spec.—1-10-21—M&T—1500 Blks.

E 47077 HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001

CERTIFICATE OF DEATH.

E 47077
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (NO.) Monument & Bway ST. 3-5 (WARD)

2-FULL NAME Mr. Samuel Rosenblatt

(a) RESIDENCE NO. 248 S. Eden ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE: Years 55 — Months — Days — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Wolf Rosenblatt

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Rachael —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Nathan Rosenblatt

(Address) 248 S. Eden St.

Filed JUN 23 1929 19 [illegible] C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 1929.

17 I HEREBY CERTIFY, That I attended deceased from Feb. 4, 1929. to June 21, 1929.

that I last saw him alive on June 21, 1929.

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Hypertrophy of Prostate Gland

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

(duration) yrs. mos. 1/2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of May 2, 1929

Was there an autopsy? yes What test confirmed diagnosis? Physical Signs

(Signed) [illegible] M. D.

19 (Address) [illegible] Sinai Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Zion Carmel

DATE OF BURIAL: 6/23 1929

20 UNDERTAKER: Jack Lewis 1429 E. Balto St.

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47078 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 47078

1—PLACE OF DEATH Altamont Hotel — REGISTERED NO.

CITY OF BALTIMORE: (No. Eutaw Place ST. Lanvale 11-24 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Josephine C. Dochez

(a) RESIDENCE NO. Eutaw Place ST. Lanvale WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: White

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (write the word): Widow

5a If ~~married~~, widowed, or ~~divorced~~ ~~HUSBAND~~ of (or) WIFE of: Late Louis C. Dochez

6 DATE OF BIRTH (month, day, and year): March 24 1841

7 AGE: Years 88 | Months | Days | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Ellicott City

PARENTS

10 NAME OF FATHER: C. Detrick

11 BIRTHPLACE OF FATHER (city or town) (State or country): France

12 MAIDEN NAME OF MOTHER: E. Wallis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): France

14 Informant: Dr C. R. Dochez

(Address): New York City

15 JUN 23 1929 G. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 22 1929

17 I HEREBY CERTIFY, That I attended deceased from July, 1919, to June 22, 1929, that I last saw her alive on June 21, 1929, and that death occurred, on the date stated above, at 10.15 A.M.

The CAUSE OF DEATH* was as follows:

Myocarditis about (duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No — Date of

Was there an autopsy? No —

What test confirmed diagnosis? None —

(Signed) Chas W Lamond — M. D.

June 22, 1929 (Address) 132 Saint Ann, Balto Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Francis Xavier Cabingdon Md Harford Co	June 27 1929
20 UNDERTAKER	ADDRESS
Henry Watkins Sons Co	Oakland Ave Catonsville

Important: See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 47079

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 47079

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4215 White Ave., Raspeburg ST. 26th WARD) 26-42

2-FULL NAME Ellen Florence Atkinson

(a) RESIDENCE NO. 4215 White Ave., Raspeburg, ST., 26th WARD
(Usual place of abode)
Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of John F. Atkinson

6 DATE OF BIRTH (month, day, and year) December 25, 1867

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
61	5	26	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer) 0
(c) Name of employer

9 BIRTHPLACE (city or town) Richmond
(State or country) Virginia

PARENTS

10 NAME OF FATHER Henry Frankland

11 BIRTHPLACE OF FATHER (city or town)
(State or country) England

12 MAIDEN NAME OF MOTHER Mary J. Morrison

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14
Informant Mrs. E. P. Fellenbaum,
(Address) Havre De Grace, Md.

15 Filed ... 19..

N 231929

C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21, 1929

17

I HEREBY CERTIFY, That I attended deceased from January . 1927 . to June 21, . 1929 .

that I last saw her alive on June 21, . 1929,

and that death occurred, on the date stated above, at 9A. m.

The CAUSE OF DEATH* was as follows:

Chr. Endocarditis and Myocarditis (mitral regurgitation)

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral embolism

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) A. L. Wilkinson M. D.

6/21 1929 (Address) 5713 Belair Rd., Raspeburg, Md

A. L. Wilkinson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: June 24, 29

20 UNDERTAKER: Frederick Loeschner — ADDRESS: Fulkerson

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 47986 / 22698 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47080

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 9-9 WARD)

2-FULL NAME Dr Fred W. Smith

(a) RESIDENCE NO. New Hartford New York St. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs F W Smith

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE: Years 51; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Physician

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): N.Y.

PARENTS

10 NAME OF FATHER: W. A. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ohio

12 MAIDEN NAME OF MOTHER: Anne Hinds

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N.Y.

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

JUN 23 1929

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 1929

17

I HEREBY CERTIFY, That I attended deceased from June 11, 1929, to June 21, 1929, that I last saw h[illegible] alive on June 21, 1929 and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Brain tumor, malignant

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of June 21, 1929

Was there an autopsy? Partial yes removal

What test confirmed diagnosis?

(Signed) I. Ridgeway Trimble M. D.

6-21, 1929 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Rockland Mem Park | DATE OF BURIAL: 6/23/29

20 UNDERTAKER: Richard Ahrens | ADDRESS: Joseph Ahrens 221 Bway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

2 2 E 47081

HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 47081

CERTIFICATE OF DEATH.

× 59

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-4 WARD)

2-FULL NAME Clara Michalek

(a) RESIDENCE NO. 33 Eccleston St., WARD Pitts - Pa
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
24			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerical 009

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Pa -

PARENTS

10 NAME OF FATHER Stanley Michalek

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ga -

12 MAIDEN NAME OF MOTHER Anna Przybylt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ga -

14 Informant: Ricardo
(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUN 23 1929, 19 [illegible] JAMES A. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 22 1929

17 I HEREBY CERTIFY, That I attended deceased from June 21, 1929, to June 22, 1929, that I last saw her alive on June 22, 1929, and that death occurred, on the date stated above, at 3 30 P m.

The CAUSE OF DEATH* was as follows:

Hypophyseal tumor

(duration) 1 yr. yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 22 VI. 29

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) H. C. Goodpasture M. D.

6/22, 19 29 (Address) John Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pittsburg Pa — DATE OF BURIAL: 6/23/29

20 UNDERTAKER: Joseph Ahrens — ADDRESS: 221 Bway

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47082 — E 47082

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE (No.) 1915 (St.) Druid Hill Ave (WARD)

REGISTERED NO. 91-02

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George N. Cole

(a) RESIDENCE NO. 1915 (St.) Druid Hill Ave WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Eliza J. Cole

6 DATE OF BIRTH (month, day, and year): 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Waiter

(b) General nature of industry, business, or establishment in which employed (or employer): 0/0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Easton Md.

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Eliza J. Cole

(Address) 1915 Druid Hill Ave

15 Filed JUN 25 1929, 19 — HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 20/29

17

I HEREBY CERTIFY, That I attended deceased from May 1, 1929, to June 20, 1929, that I last saw him alive on June 20, 1929 and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Degeneration

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. E. McCard M. D.

6 Jun 19 29 (Address) 2005 Hillen

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sec. Auburn — DATE OF BURIAL 6/23 19 29

20 UNDERTAKER: Samuel D. Greenberg — ADDRESS 1778 N. Bdle

Spec.—1-10-21—M&T—1500 Bks.

E 47083 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

29 E 47083

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 640 E 36th ST., 9-47 WARD)

2-FULL NAME Catherine Myers

(a) RESIDENCE NO. 640 E. 36 ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE: 69 Years | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home Wife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John Hoffman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Catherine Silkenbrod

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Miss M. E. Bullock

(Address) 2043 E. Lombard

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

UN 231929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 20 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1928, to June, 1929, that I last saw her alive on June, 1929 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 8 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John H Amerey, M. D.

, 19 (Address) 1603 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cem London Park — DATE OF BURIAL June 20 1929

20 UNDERTAKER: Wm Cook — ADDRESS 1267 31st E

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47084

CERTIFICATE OF DEATH

90 E 47084

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2043 E Lombard ST., 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Fannie Bullock

(a) RESIDENCE NO. 2043 E Lombard St.
(Usual place of abode) ST. WARD

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Winfield Bullock

6 DATE OF BIRTH (month, day, and year) Oct 30/50

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78	7	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Harford Co
(State or country) Md

PARENTS

10 NAME OF FATHER James Todd

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Penna.

12 MAIDEN NAME OF MOTHER Mary Osborn

13 BIRTHPLACE OF MOTHER (city or town) Harford Co
(State or country) Md

14 Informant Miss M E Bullock

(Address) 2043 E Lombard St

15 Filed [illegible] 19 [illegible] HARRISON JONES, M. D.
Registrar

N 231923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21, 1929

17 I HEREBY CERTIFY, That I attended deceased from June, 1928, to June 21, 1929, that I last saw h[illegible] alive on June 21, 1929 and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Arterio-Sclerosis
Chr. Myocarditis
(Cerebral apoplexy)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral apoplexy

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? residence

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Orall J. Templin M. D.

6/27, 1929 (Address) 1001 E Fayette St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	June 24 1929

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul St

Spec.—1-12-23—M&T—500 Bks.

47085

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 47085
REGISTERED NO.

1-PLACE OF DEATH The Church Home & Infirmary
CITY OF BALTIMORE: (NO. ST. 9-47 WARD
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Nelson R Holmes.

(a) RESIDENCE NO. 3201 Avon ave ST. WARD
(Usual place of abode)
Length of residence in city or town where death occurred 27 yrs 8 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: white
5 Single, Married, Widowed, or Divorced, (write the word): single
5a If married, widowed, or divorced HUSBAND of or) WIFE of: —
6 DATE OF BIRTH (month, day, and year): Oct 9 1901
7 AGE — Years: 27 — Months: 8 — Days: 12 — If LESS than 1 day, hrs. or min.:
8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Secretary 086
(b) General nature of industry, business, or establishment in which employed (or employer): Carroll Independent Coal Co
(c) Name of employer:
9 BIRTHPLACE (city or town) (State or country): Baltimore Md
PARENTS
10 NAME OF FATHER: Robert N. Holmes
11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md
12 MAIDEN NAME OF MOTHER: Carrie G. Reed
13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md
14
Informant: Robert N. Holmes
(Address) 3201 Avon ave
15 Filed 2 31929, 19 H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 21, 1929
17
I HEREBY CERTIFY, That I attended deceased from June 16, 1929. to June 21, 1929, that I last saw h[illegible] alive on June 21, 1929, and that death occurred, on the date stated above, at 9.35 P. m.
The CAUSE OF DEATH* was as follows:
Appendicitis, acute

(duration) yrs. mos 7 ds.
CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs. mos. 3 ds.
18 Where was disease contracted if not at place of death?
Did an operation precede death? Yes Date of June 17, 1929
(Appendectomy)
Was there an autopsy? Yes.
What test confirmed diagnosis? Operation. Autopsy
(Signed) Fred R. Landon, M. D.
, 19 (Address) The Church Home Inf.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: June 24 1929
20 UNDERTAKER: Chas. D. Black — ADDRESS: 742 W. North ave

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—2-20-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47086

CERTIFICATE OF DEATH

38 E 47086

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1725 n. Spring ST., 9-17 WARD)

2—FULL NAME Charles William Heater

(a) RESIDENCE NO. 1725 n. Spring ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
m	C	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 7. 1928

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		10 9	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) gas

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Bolles. Md.

PARENTS

10 NAME OF FATHER Sidney Heater

11 BIRTHPLACE OF FATHER (city or town) (State or country) N.C.

12 MAIDEN NAME OF MOTHER Queenie Tolas

13 BIRTHPLACE OF MOTHER (city or town) Stafford Co (State or country) Va.

14 Informant Sidney Heater
(Address) 1725 n. Spring

15 231525 19 E. HAMILTON JONES M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21. 29

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1929, to June 21, 1929, that I last saw h[illegible] alive on June 21, 1929, and that death occurred, on the date stated above, at 11:45 P. m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus

(duration) yrs. 1 mos. dys

CONTRIBUTORY (Secondary) Acute Myocarditis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms.

(Signed) W. L. Kelly, M. D.

19 (Address) 1420 E. Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary Cem.

DATE OF BURIAL 8/23/29

20 UNDERTAKER George J. Puth

ADDRESS 735 Hanover

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47087

CERTIFICATE OF DEATH.

E 47087

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) West East Gwl ST., (WARD) 19-59

2-FULL NAME Mrs. Sophie Rupp.

(a) RESIDENCE No. 2503 Salem ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., If of foreign birth? 46 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Franklin Rupp.

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE Years 59 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Frank Kirchner.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER —?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Mrs. Rupp (Address) 2503 Salem St

15 [illegible] 19 [illegible] Registrar

UNZ31929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 1929

17 I HEREBY CERTIFY, That I attended deceased from June 20, 19 29 to June 21, 19 29 that I last saw her alive on June 21, 19 29 and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetic Coma (duration) yrs. mos. 1hr ds.

18 Where was disease contracted if not at place of death? At Home.

Did an operation precede death? No Date of —

Was there an autopsy? No What test confirmed diagnosis? Laboratory (Serum Blood Sugar)

(Signed) Benjamin Sapinsley M. D.

, 19 (Address) West Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery.

DATE OF BURIAL 6-24-1929

20 UNDERTAKER M. Fahey & Sons

ADDRESS 15-17 W. North Ave

Print or write plainly. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E47088

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 118-002

E 47088

REGISTERED NO.

1—PLACE OF DEATH (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. University Hospital ST. 4-30 WARD)

2—FULL NAME Phillip Burgan

(a) RESIDENCE NO. Hagerstown Md ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 16 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Breakman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer H M R R.

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER Ethel E Burgan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Izora E Bachtell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Philip Burgan
(Address) Hagerstown

15 Filed [illegible], 19 [illegible] LAWSON JONES, M. D.
Registrar

N 231929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22nd, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 6th, 1929, to June 22nd, 1929

that I last saw him alive on June 22nd, 1929

and that death occurred, on the date stated above, at 10.05 p m.

The CAUSE OF DEATH* was as follows:

Chronic intestinal obstruction from congenital bands about terminal portion of caecum

(duration) 15 yrs. mos. ds.

CONTRIBUTORY (Secondary) Peritonitis general, terminal hypostatic pneumonia (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of June 7th 1929

Was there an autopsy? Yes

What test confirmed diagnosis? Operation & Autopsy

(Signed) Lewis A. Tucker, M. D.

6-22-1929 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Rest Haven Cemetery	June 25 1929
20 UNDERTAKER	**ADDRESS**
C M Suter & Sons	Hagerstown

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47089

CERTIFICATE OF DEATH.

118-001

E 47089

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St Agnes Hospital (St.) 19-28 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary Miller

(a) RESIDENCE No. 108 S. Gilmor St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of John Miller

6 DATE OF BIRTH (month, day, and year) Feb. 14 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	39	4	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER John Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Emma English

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant John Miller (Address) 108 S. Gilmor St.

15 Filed 241929 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21 19 29

17 I HEREBY CERTIFY, That I attended deceased from June 8 19 29 to June 21 19 29

that I last saw h alive on June 21 19 29

and that death occurred, on the date stated above, at 9 00 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Degeneration

Myocardial Insufficiency

Ventral Hernia

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary) Operation & Cardiac Failure (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of June 20, 29

Was there an autopsy? No

What test confirmed diagnosis? Operation & Physical

(Signed) Nicholas P. Bonelli M. D.

19 (Address) St Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL June 24 1929

20 UNDERTAKER Harry H. Kirkpatrick — ADDRESS 1521 W. Fayette St.

TION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47090 166 **E 47090**

CERTIFICATE OF DEATH.

REGISTERED NO. 2443

1-PLACE OF DEATH

City of BALTIMORE: (No.) Union Memorial Hospital (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jane A. Hutchins

(a) RESIDENCE NO. 5303 Harford ave St. / Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? 7 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 ~~Single~~, Married, ~~Widowed~~ or ~~Divorced~~. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ernest Hutchins

6 DATE OF BIRTH (month, day, and year): June 21st 1880

7 AGE: Years: 49. Months: Days: 1 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: 37

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town): England

(State or country)

PARENTS

10 NAME OF FATHER: William Brown

11 BIRTHPLACE OF FATHER (city or town): England

(State or country)

12 MAIDEN NAME OF MOTHER: Ann Mullon

13 BIRTHPLACE OF MOTHER (city or town): England

(State or country)

14 Informant: Ernest Hutchins

(Address) 5303 Harford ave

15 Date: 19 Signature: C. HAMPSON JONES, M. D.

Registrar

Per

UN 241929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-22 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) and from other sources find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Bronchitis of Pneumonia Contributory Cerebral Embolism

(Duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary) .....

(Duration) .....yrs. .....mos. .....ds.

(Signed) [signature] M. D.

(Coroner)

6/23 1929 (Address) 7362 Roland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs.. mos.. ds. In the State yrs.. mos.. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, (CREMATION) OR REMOVAL: London Pk Cemetery Date of Burial: June 24 29

20 UNDERTAKER: J. A. Kranse & Son ADDRESS 703 Harford

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47091

CERTIFICATE OF DEATH

E 47091

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 505 S. Robinson ST., 1 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Agnes E. Kolb.

(a) RESIDENCE NO. 505 S. Robinson ST., 1 WARD
(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles Kolb.

6 DATE OF BIRTH (month, day, and year) June 29th 1882

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
46	11	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Trachsel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Mary A. Waltz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Edward Kolb. Husband

(Address) 505 S. Robinson St

15 Filed July 24 1929 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21st/29

17 I HEREBY CERTIFY, That I attended deceased from May 30, 1929, to June 21, 1929, that I last saw her alive on June 21, 1929, and that death occurred, on the date stated above, at 6 10/P. m.

The CAUSE OF DEATH* was as follows:

Acute Dilatation
Acute Endocarditis.

CONTRIBUTORY (Secondary) Acute Chronic Nephritis. (duration) yrs. mos. 1 wk. ds.

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Exam. by Dr. Doyle & Hart.

(Signed) W. E. McCandlish M. D.

July 23, 1929 (Address) 3508 Bond St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL June 24 1929

20 UNDERTAKER Lilly & Zeiler Inc.

ADDRESS 403 S. Wolfe St

Spec.—1-10-21—M&T—1500 Bks.

Dr. Carman

E 47092 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47092

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3221 Guilford Ave ST. WARD 12 9 Caroline 14

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Elizabeth B Hunter.

(a) RESIDENCE No. 3221 Guilford Ave ST., WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX ~~Female~~

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Peter G. Hunter.

6 DATE OF BIRTH (month, day, and year) Aug 30 1846

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
82	9	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Wm Bacon.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Martha Green

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mrs Elmer Miller

(Address) 3221 Guilford Ave

15 Filed JUN 24 1929 H. HAMPSON JONES, M. D. Registrar

By ..... Clerk.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-22-1929

17

I HEREBY CERTIFY, That I attended deceased from June 16, 1929, to June 22, 1929, that I last saw her alive on June 21, 1929, and that death occurred, on the date stated above, at 10 10 A m.

The CAUSE OF DEATH* was as follows:

Acute Meningitis ~~& Influenza~~

~~Grippe~~

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage. Nephritis

Mitral murmur & Pulmonary (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? 3221 Guilford Ave

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Spinal puncture

(Signed) E. C. Carman, M. D.

6-22-, 1929 (Address) 1701 N Caroline St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Vernon Cem. Harford Co Md — DATE OF BURIAL 6-25-29

20 UNDERTAKER Bernard C Hartz — ADDRESS 1000 S Paca St

TION is very important. See instructions on back of certificates.

Spec. Cert. 29-28—L. F. S.—500 Bks.

E 47093

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

8-4

E 47093

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1023 Williams ST. 24-33 WARD)

2—FULL NAME Ella Hawk

(a) RESIDENCE NO. 1023 Williams ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Widow

a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 30/866

7 AGE — Years: 62 — Months: 7 — Days: 23 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Washington D C

PARENTS

10 NAME OF FATHER: William T Gardner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto md

12 MAIDEN NAME OF MOTHER: Mary E Atwell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto md

14 Informant: Mrs Chas R Webbert

(Address) 1023 Williams st

15 Filed [illegible] 19 [illegible] HAMILTON JONES, M. D. Registrar

N 241929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 18, 1929, to June 22, 1929

that I last saw her alive on June 22, 1929

and that death occurred, on the date stated above, at 7 30 P. m.

The CAUSE OF DEATH* was as follows:

Jacksonian Epilepsy

(duration) 10 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) 0 yrs. 1 mos. 0 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Henry T. Buettner, M. D.

June 24, 1929 (Address) 1319 Light St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Congressional Cemetery — DATE OF BURIAL: June 25 1929

20 UNDERTAKER: John F Denny — ADDRESS: Washington D C via Auto 715 L St N W

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47094

CERTIFICATE OF DEATH.

31 **E 47094**

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3049 Stricklands St. ST.) 20-24 (WARD)

2-FULL NAME Anna Helen Willms

(a) RESIDENCE No. 3049 Stricklands St. ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 3-1912

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	16	8	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Karl Willms

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Amelia Klein

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Karl Willms (Address) 3049 Stricklandst

15 Filed 2-4-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1929

17 I HEREBY CERTIFY, That I attended deceased from Feby 8 1929 to June 23 1929, that I last saw her alive on June 22 1929, and that death occurred, on the date stated above, at 12:30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Pulmonary Tuberculosis

(duration) two Hmonths

CONTRIBUTORY (Secondary) None

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Uncertain

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs & Braulli

(Signed) C. W. Ingram M. D.

19 (Address) 2429 N. Wolfe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL June 25 1929

20 UNDERTAKER Jarrett Leyton ADDRESS 1600 W North Ave

FOR EVERY important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47095

CERTIFICATE OF DEATH

E 47095

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St., 4-34 Ward)

2-FULL NAME Willoughby Hoggard (Jr)

(a) RESIDENCE NO. Price, Md St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed or Divorced. (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): December

7 AGE: Years 7 | Months | Days | IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country): Md

PARENTS

10 NAME OF FATHER: Willoughby Hoggard

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Md

12 MAIDEN NAME OF MOTHER: Amelia Snyder

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Md.

14 Informant: Amelia Hoggard
(Address) 525 La Price Md.

15 Filed ... 19... C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 23 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebro - Spinal Meningitis

(duration) ... yrs. ... mos. 10 ds.

CONTRIBUTORY (Secondary): Patent Foramen Ovale

(duration) 7 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Price, Md

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edgar Zeller, M. D.

6/24 1929 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cem. DATE OF BURIAL: June 25th 1929

20 UNDERTAKER: Chas Lennbeck & Son ADDRESS 525 Lyndhurst St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

E 47096

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47096

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Franklin Square Hosp. 24-35-124

CITY OF BALTIMORE: (No. Calhoun & Fayette St.) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alberta Say.

(a) RESIDENCE NO. 1427 Andre. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Child

6 DATE OF BIRTH (month, day, and year): June 15 1925

7 AGE — Years: 4. Months: — Days: 4 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: George Say

11 BIRTHPLACE OF FATHER (City or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Eloise Smith

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Balto Md

14 Informant: Mrs Elsie Murphy

(Address): 1417 Andre St

15 Filed JUN 24 1929, 19

CHARLES JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 22 1929

17 I HEREBY CERTIFY, That I attended deceased from June 17, 1929, to June 22, 1929, that I last saw her alive on June 21, 1929, and that death occurred, on the date stated above, at 5 A. M. m.

The CAUSE OF DEATH* was as follows:

Liver abscess undetermined origin.

(duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 6-21-29.

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) Elizabeth Sherman, M. D.

6/22 1929 (Address) Franklin Square Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill

DATE OF BURIAL: June 24 1929

20 UNDERTAKER: Chas. L. Sparrow

ADDRESS: 102 E Fort Ave

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—2-29-28—L. F. S.—500 Bks.

E 47097

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 47097

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 7 S. Stark ST., 1-2 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Matthew Derr

(a) RESIDENCE NO. 7 S. Stark ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. 8 mos. 4 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Derr

6 DATE OF BIRTH (month, day, and year) Oct. 17/1862

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
66	8	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER John Derr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger

12 MAIDEN NAME OF MOTHER Bertha Kaiser

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country)

14 Informant Mrs. Mary Derr

(Address) 7 S. Stark

15 Filed ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24, 1929.

17 I HEREBY CERTIFY, That I attended deceased from June 3, 1929, to June 24, 1929, that I last saw h[illegible] alive on June 24, 1929 and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Arterio-Sclerosis

..... (duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

..... (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) [illegible], M. D.

6/27, 1929 (Address) 1529 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL June 25 1929

20 UNDERTAKER Jos. J. Derr — ADDRESS 156 N. Liberty

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

47098

CERTIFICATE OF DEATH

91-002

E 47098

1—PLACE OF DEATH St Joseph Hospital (If death occurred in a hospital or institution, give its NAME instead of street and number.)

REGISTERED NO.

CITY OF BALTIMORE: (No. St Joseph Hospital ST., 6 WARD)

2—FULL NAME Mary Jenkins

(a) RESIDENCE NO. 2423 E Fayette ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 84 yrs. 11 mos. 29 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 22/1845

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
84	11	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Adam Rock

11 BIRTHPLACE OF FATHER (city or town) Ger.
(State or country)

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ger

14 Informant Alma Novotny
(Address) 2423 E. Fayette St.

15 Filed , 19 HAMILTON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/21/29

17 I HEREBY CERTIFY, That I attended deceased from 6/18/29, 19, to 6/21/29, 19, that I last saw h alive on 6/21/29, 19, and that death occurred, on the date stated above, at 5:20 P. m.

The CAUSE OF DEATH* was as follows:

arteriosclerotic gangrene
of leg
Arteria - Sclerosis -

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of None

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) W B Hendrix M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL June 25 19 29

20 UNDERTAKER Jos. J. Kerr — ADDRESS 156 N. Luzerne

Spec.—2-29-28—L. F. S.—500 Bks.

E 47099 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47099

CERTIFICATE OF DEATH

51

1—PLACE OF DEATH

REGISTERED NO. 14-59

CITY OF BALTIMORE: (No. 2135 McCulloh ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sarah E. Johnson

(a) RESIDENCE NO. 2135 McCulloh ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Colored	married

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Henry T. Johnson

6 DATE OF BIRTH (month, day, and year) Feb 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	56	4		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) "

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14

Informant Henry T. Johnson

(Address) 2135 McCulloh

15

Filed C. HAMPSON JONES, M. D. Registrar

241929 Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21, 1929

17

I HEREBY CERTIFY, That I attended deceased from Nov 30, 1928 to June 21, 1929,

that I last saw her alive on June 20, 1929

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urinalysis

(Signed) D. M. Beard, M. D.

6/21, 1929 (Address) 2005 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	6/24/29

20 UNDERTAKER Mrs. Geo. H. Holland ADDRESS 1601 Druid Hill Ave

Spec.—2-29-28—L. F. S.—500 Bks.

E 47100

HEALTH DEPARTMENT—CITY OF BALTIMORE

21-001

CERTIFICATE OF DEATH

E 47100

1—PLACE OF DEATH

CITY OF BALTIMORE, (No.) 3911 Chatham R (ST.) 15-63 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Clara Elizabeth Davis

(a) RESIDENCE NO. 3911 Chatham R ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6 DATE OF BIRTH (month, day, and year): July 29-1863

7 AGE — Years: 65 Months: 10 Days: 23 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): None

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): Towson Md

PARENTS

10 NAME OF FATHER: Alexander Parlett

11 BIRTHPLACE OF FATHER (city or town) (State or country): Towson Md

12 MAIDEN NAME OF MOTHER: Lucy Jackson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Faulkner Davis

(Address) 3911 Chatham R

15 Filed 24 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 21 - 1929

17 I HEREBY CERTIFY That I attended deceased from 1929, to June 21, 1929

that I last saw her alive on June 21, 1929

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Meningitis caused by infection of Ethmoidal and Sphenoidal Sinuses on left side

(duration) yrs. mos. 3 days.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Patient had infection of sinuses on left side for Remained home in bed sinuses June 11-'29

Did an operation precede death? Date of

Was there an autopsy? No X Ray Photos Transillumination

What test confirmed diagnosis?

(Signed) Edmund Rumsey, M. D.

, 19 (Address) 812 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Prospect Hill Towson — DATE OF BURIAL: June 24 1929

20 UNDERTAKER: F. P. Sudano & Son — ADDRESS: Towson

Spec.—2-29-28—L. F. S.—500 Bks.

E 47101 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47101

CERTIFICATE OF DEATH

REGISTERED NO. 90 17-55

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4117 Kenehaw Ave WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Wilbur F. Shillenberg Sr

(a) RESIDENCE NO. 4117 Kenehaw Ave WARD
(Usual place of abode)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widower

a If married, widowed or divorced HUSBAND of (or) WIFE of Fannie Shillenberg

6 DATE OF BIRTH (month, day, and year) Dec 17-1850

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
78	6	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Dominick Shillenberg

11 BIRTHPLACE OF FATHER (city or town) (State or country): ?

12 MAIDEN NAME OF MOTHER: ? Warfield

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Wilbur F. Shillenberg

(Address) 4117 Kenehaw Ave

15 Filed ..... 19..... Registrar

C. HARRISON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21-29

17 I HEREBY CERTIFY, That I attended deceased from Jan 1926 to June 21 1929

that I last saw h alive on June 21 1929

and that death occurred, on the date stated above, at 12 40 A. m.

The CAUSE OF DEATH* was as follows:

acute dilitation of heart

(duration) yrs. 2 hours mos. ds.

CONTRIBUTORY (Secondary) Mitral regurgitation

(duration) 4 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual signs

(Signed) W. H. Bynum M. D.

6/22 1929 (Address) 616 Woodington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: June 24 1929

20 UNDERTAKER: Wm J. Trekner Sons — ADDRESS: N. 4 Pa

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47102

CERTIFICATE OF DEATH

100-001

E 47102

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Baltimore City Hospitals (WARD) 9 B

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Dwyer

(a) RESIDENCE NO. 1100 Holbrook ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Record

(Address)

15 Date received JUN 24 1929, 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/22/29

17 I HEREBY CERTIFY, That I attended deceased from 5/19, 1929, to 6/22, 1929, that I last saw h[illegible] alive on 6/22, 1929 and that death occurred, on the date stated above, at 11 9a. m.

The CAUSE OF DEATH* was as follows:

Cellulitis of scalp

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. U. Crumpton, M. D.

6/22, 1929 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters Cemetery

DATE OF BURIAL June 26 1929

20 UNDERTAKER Geo. F. Ruth

ADDRESS 1730 Harford

Spec.—2-29-28—L. F. S.—500 Bks.

E 47103

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 ✓ E 47103

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1400 Bank at ST. 3-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lena Costagneta

(a) RESIDENCE NO. 1400 Bank st ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: White

5 Single, ~~Married~~, ~~Widowed~~, or ~~Divorced~~ (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Jan. 1 1903

7 AGE: Years 26 | Months 4 | Days 22 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework.

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Italy.

PARENTS

10 NAME OF FATHER: Alex Costagneta.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy.

12 MAIDEN NAME OF MOTHER: A. Maggiani.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy.

14 Informant: Andrew Costagneta.

(Address) 1400 Bank st.

15 N 24 1929 19 Dat. C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6-23-29

17 I HEREBY CERTIFY, That I attended deceased from June 1st 1924 to June 23rd 1929.

that I last saw h alive on June 23rd 1929

and that death occurred, on the date stated above, at 4:15 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis
Interstitial

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Pulmonary Edema

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. J. Faulkner, M. D.

19 (Address) 1191 N. Milton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery.

DATE OF BURIAL: Jan. 26 1929.

20 UNDERTAKER: Geo. F. Rutt.

ADDRESS: 1735 Harford ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47104

CERTIFICATE OF DEATH

31 E 47104

REGISTERED NO. 28163

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Baltimore City Hospitals ST., (If not in hospital, give WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank Douglas

(a) RESIDENCE NO. 6816 Reisterstown Road ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Deny Douglas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Harriett Warfield

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Records

(Address) Balto. City Hospital

15 241929 C. Hampson Jones, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 26, 1929, to June 21, 1929, that I last saw him alive on June 21, 1929 and that death occurred, on the date stated above, at 7.30 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Humfe Smith M. D.

6-21-29 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL 6-24-1929

20 UNDERTAKER: Daniel Easter — ADDRESS 916 Pr

Spec.—1-10-21—M&T—1500 Bks.

Sine

E 47105

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47105

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mrs Guesthouse (St.) 13-51 (WARD) 109002

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theodore Sine

(a) RESIDENCE NO. 1319 Ellwood Ave. WARD .....

(Usual place of abode) (If non-resident, give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F (M) 4 COLOR OR RACE W 5 (Single) Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) July 6 1928

7 AGE Years 11 Months Days 17 If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Edward Sine

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Maude Ford

13 BIRTHPLACE OF MOTHER (city or town) Md. (State or country) .....

14 Informant Edward Sine (Address) .....

15 Filed ..... 19 ..... HAMPSON JONES, M. D. Registrar

UN 24 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/23/29

17 I HEREBY CERTIFY, That I attended deceased from 6/23/29 to 6/23/29, that I last saw him alive on 6/23/29, and that death occurred, on the date stated above, at 9 30 m.

The CAUSE OF DEATH* was as follows: Cerebral Abscess

(duration) yrs. ..... mos. 6 wks

CONTRIBUTORY (secondary) Bilateral Pneumonia

Abscess of Cerebellum (duration) yrs. ..... mos. 1 wk ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinical

Signed Edward Sine, M. D.

(Address) 1319 Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Mary's Hampden

DATE OF BURIAL June 26 1929

20 UNDERTAKER Chesworth & Son

ADDRESS 9615 Liberty

TION is very important. See instructions on back of certificate. Exact statement of OCCUPA-

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47106

CERTIFICATE OF DEATH

E 47106

1—PLACE OF DEATH St Joseph's Hospital — REGISTERED NO. 9-47

CITY OF BALTIMORE; (No. Caroline & Oliver Sts ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Elizabeth Phillips

(a) RESIDENCE NO. 3211 Westerwald Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Phillips

6 DATE OF BIRTH (month, day, and year) Jan 2, 1855

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
74	5	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md

PARENTS

10 NAME OF FATHER Wm Hildebrand

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Susan Saylor

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant James G. Phillips

(Address) 3211 Westerwald Ave.

Filed JUN 24 1929 E. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-23-29

17 I HEREBY CERTIFY, That I attended deceased from May 1st, 1929, to June 23, 1929

that I last saw h.. alive on June 23, 1929

and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Embolism

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 5-21-29

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) E Messina, M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	June 26 19 29
20 UNDERTAKER	ADDRESS
Chenowith & Son	2617 Chestnut Ave

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 47107 PLACE OF DEATH

E 47107 REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

City of BALTIMORE: (No. 3419 Kesmick 27-55 162 Ward)

2-FULL NAME Baby Girl Bopst

(a) RESIDENCE NO. 3419 Kesmick St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6-22-29

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country) Balto Md

PARENTS

10 NAME OF FATHER Louis Bopst

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Balto Md

12 MAIDEN NAME OF MOTHER Catherine Hainet

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) Balto Md

14 Informant Louis Bopst

(Address) 3419 Kesmick Road

15 Filed ..... 19.....

HAMILTON JONES, M. D.

Registrar

JUN 24 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-23-29 19

17 I HEREBY CERTIFY, That I attended deceased from 6-22, 1929, to 6-23, 1929, that I last saw h.e.r alive on 6-23, 1929, and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted? Home

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J N Wilson M. D.

, 19 (Address) 823 W 36th

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Hempstead Date of Burial: June 24 1929

20 UNDERTAKER: Ebenezer Mem Chestnut ADDRESS 361 Chestnut Ave

Very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47108

E 47108

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4651 Park Hts Ave ST., 27-55 WARD)

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jermiah B Townshend

(a) RESIDENCE NO. 4651 Park Hts Ave

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

WARD

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Hannah M Townshend

6 DATE OF BIRTH (month, day, and year): Feb 6 67

7 AGE — Years: 62 | Months: 4 | Days: 16 | If LESS than 1 day, ...hrs. or ....min.: 3 28

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer): Grocery 06

(c) Name of employer

PARENTS

9 BIRTHPLACE (city or town) (State or country): Balto Md

10 NAME OF FATHER: J Townshend

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs Hannah M Townshend

(Address) 4651 Park Heights

15 Filed JUN 25 1929 HAMPSON ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 22 29

17 I HEREBY CERTIFY, That I attended deceased from June 21, 19 29, to June 22 19 29

that I last saw him alive on June 22, 19 29

and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

CONTRIBUTORY (Secondary) Mitral Stenosis (duration) — yrs. — mos. 1 ds.

Unknown (duration) X yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) C. B. Emrich M. D.

6-22, 1929 (Address) 4936 Park Hts Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cemetery Zuganore Funeral Co Inc — DATE OF BURIAL: June 25 1929

20 UNDERTAKER: W M Routson — ADDRESS: 2223 Eutaw Mkt

Spec.—1-10-21—M&T—1500 Bks.

226409

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-001 E 47109

1-PLACE OF DEATH E 47109

REGISTERED NO.

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL (ST.) (WARD) 27-43

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Carter

(a) RESIDENCE No. 5708 Kenmell Ave - WARD Raspberry
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 10/29

7 AGE: Years — Months — Days 13 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md -

PARENTS

10 NAME OF FATHER: Harry H. Carter.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore. Md.

12 MAIDEN NAME OF MOTHER: Jeannette Carter

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ritzy Virginia

14 Informant: Records — (Address) JOHNS HOPKINS HOSPITAL

15 FILED JUN 24 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 23 1929

17 I HEREBY CERTIFY, That I attended deceased from June 18, 1929, to June 23, 1929, that I last saw her alive on June 23, 1929, and that death occurred, on the date stated above, at 4:50 P.M.

The CAUSE OF DEATH* was as follows:

Pneumonia - bronchial -

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary): Prematurity

(duration) yrs. mos. 13 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Phys Exam

(Signed) J. C. Goodwin, M. D.

June 24, 1929 (Address) J H Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, ~~CREMATION OR REMOVAL~~ — DATE OF BURIAL

Prospect Hill Towson Md June 24 1929

20 UNDERTAKER — ADDRESS

Ellis S. White 2554 Madison Ave

TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 47110

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

143-001

E 47110

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Joseph Hospital St., 710 Ward)

2-FULL NAME Mildred Poehlman

(a) RESIDENCE NO. 2512 McElderry St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of John W. Poehlman

6 DATE OF BIRTH (month, day, and year) Feb 22/1905

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	24	4	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer) housework
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER John H. Kolbe

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Georgianna Jubb.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant John W. Poehlman
(Address) 2512 McElderry St

Filed JUN 24 1929 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Sepsis- Gangrene Uterine Cervix..

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Self induced abortion.

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature] M. D.

6/24/29 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn — DATE OF BURIAL 6/25 1929

20 UNDERTAKER Philip Henry — ADDRESS 2006 Orleans St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

47111

CERTIFICATE OF DEATH

74E 001 47111

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 30 N. Milton Ave ST. 6-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Wm. B. K. Thilkel

(a) RESIDENCE NO. 30 N. Milton Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Annie Horner

6 DATE OF BIRTH (month, day, and year) May 19/1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	1	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Manager

(b) General nature of industry, business, or establishment in which employed (or employer) Thilkel Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John Thilkel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Annie Thilkel

(Address) 30 N. Milton Ave

15 Filed JUN 24 1929 19 HAMILTON [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23/29

17 I HEREBY CERTIFY, That I attended deceased from June 9 . 1929 to June 22 1929.

that I last saw h[illegible] alive on June 22 1929

and that death occurred, on the date stated above, at 6 [illegible] m.

The CAUSE OF DEATH* was as follows:

Cholecystitis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilation

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

. 19 (Address) 119 N. Milton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Pk Cem	June 26 1929
20 UNDERTAKER Philips & Herwig	ADDRESS 2316 Eden St.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47112 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31

REGISTERED NO. E 47112

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 403 W 28th St., 12-51 WARD)

2—FULL NAME Charles F Duffy

(a) RESIDENCE NO. 403 W 28th St., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced (write the word): Married

6a If married, widowed or divorced HUSBAND of (or) WIFE of: Cora E Duffy

6 DATE OF BIRTH (month, day, and year): Nov 14 1894

7 AGE: Years 34 Months 7 Days 8 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: RR Brakeman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Oliver H Duffy

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Ellen Foley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Cora E Duffy

(Address) 403 W 28th St

N 24 1929 19 H. HAMILTON JOHNS, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6-29-29

17 I HEREBY CERTIFY, That I attended deceased from 1-1-29 to 6-29-29, 19 ; that I last saw him alive on 6-26-29, 19 ; and that death occurred, on the date stated above, at 3 & 1 m.

The CAUSE OF DEATH was as follows: Pul Tuberculosis

CONTRIBUTORY (Secondary) Laryngeal Tuberculosis (duration) 6 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown (duration) yrs. 2 mos. ds.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Finding

(Signed) [illegible] M. D.

(Address) 6009 Belair Rd

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem — DATE OF BURIAL: 6/25/29

20 UNDERTAKER: George A Staley — ADDRESS: Fulton & Fayette

Spec.—2-29-28—L. F. S.—500 Bks.

E 47113

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 47113

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST. 16-31 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Christopher Lang (Lamb)

(a) RESIDENCE NO. Unknown ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Robert Lamb

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Margaret ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed JUN 24 1929 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 21, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 14, 1929, to June 21, 1929, that I last saw him alive on June 21, 1929, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Tuberculous peritonitis

(duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical and lab.

(Signed) Henry C. Smith, M. D.

6-22-1929 Address Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Faith Cem. DATE OF BURIAL 7/23/29

20 UNDERTAKER Chas. E. Evans & Co. ADDRESS 118 Saint Paul.

Commissioner of Health

JUN 21 1929

UNIVERSITY OF MARYLAND

Cor.—10-10-29—A Co.—100 Bks.

E 47114

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

66

E 47114

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Franklin Sq. Hospital St., 19-26 Ward)

2-FULL NAME Wm A. Fischer

(a) RESIDENCE NO. 1304 W. Lexington St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of cesidence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, oc divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 12 - 1884

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	45	4	10	

8 OCCUPATION OF DECEASED
(a) Tcade, profession or particular kind of work R. R.
(b) General nature of industry, business, or establishment in which employed (or employer) Clerk
(c) Name of employer

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER Geo. A. Fischer

11 BIRTHPLACE OF FATHER (city or town) Balto
(State oc country)

12 MAIDEN NAME OF MOTHER Margaret A. Wisbacher

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant Margaret A. Feldmacher
(Address) 334 Fulton Ave

Filed JUN 24 1929 M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Acute Alcoholism

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. H. Brooks, M. D.

June 22 1929 (Address) 3691 Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side foc additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Olivet Cemetery	June 25, 29
UNDERTAKER	ADDRESS
George L. Ashman Home Funeral Dir.	

IMPORTANT—Fill out in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47115 HEALTH DEPARTMENT—CITY OF BALTIMORE 23 ✓ **E 47115**

CERTIFICATE OF DEATH

1—PLACE OF DEATH St Joseph's Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. Caulvin + Howard Sts ST 10-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph Vaughan

(a) RESIDENCE NO. 1134 Homewood Av ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 25-1872

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56	9	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk 007

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER John Vaughan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Trinehan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Annie Vaughan

(Address) 1134 Homewood Ave Baltimore Md

15 Filed 2-4 1929, By HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-22-29

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1929, to June 22, 1929, that I last saw h alive on June 22, 1929 and that death occurred, on the date stated above, at 12-mid-night

The CAUSE OF DEATH* was as follows:

Encephalitis Lethargica

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) V. Mesina, M. D.

, 19 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	6/25 1929

20 UNDERTAKER Chas. F. Kraus & Son ADDRESS 111 West Royal Ave

Spec.—2-29-28—L. F. S.—500 Bks.

E 47116

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

151

E 47116

1—PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 815 S. Conkling ST., 26 WARD)

2—FULL NAME John V. Sullivan

(a) RESIDENCE NO. 815 S. Conkling ST., 26 WARD
(Usual place of abode)

Length of residence in city or town where death occurred ... yrs. ... mos. ... ds. How long in U. S., if foreign birth? ... yrs. ... mos. ... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary M. Sullivan

6 DATE OF BIRTH (month, day, and year) Oct. 25th 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57	7	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Iron Moulder

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Jeremiah J. Sullivan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Delia Joyce

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary M. Sullivan (Address) 815 S. Conkling St.

15 6-24 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22nd 1929

17 I HEREBY CERTIFY, That I attended deceased from 6/10 1929 to 6/22 1929 that I last saw h[e] alive on 6/22 1929 and that death occurred, on the date stated above, at 12 45 P. m.

The CAUSE OF DEATH* was as follows:

Paymonds. Chronic passive Congestion. Liver. Kidneys Complication.

... (duration) 7 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Pulmonary oedema

... (duration) ... yrs. ... mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? ...

(Signed) [signature] M. D.

6-24 1929 (Address) 633 S. Conkling

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	June 25 1929
20 UNDERTAKER Lilly & Sons	ADDRESS 400 N. Howard St

Spec.—2-29-28—L. F. S.—500 Bks.

E 47117 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47117

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 3508 Bank ST. 26-31 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Patrick McGuinness

(a) RESIDENCE NO. 3508 Bank ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single.

6 If married, widowed, or divorced (HUSBAND of (or) WIFE of): Divorced.

6 DATE OF BIRTH (month, day, and year): Jan. 15-1894

7 AGE: Years 35 | Months 5 | Days 5 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer): Automobile.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Co. Maryland.

PARENTS

10 NAME OF FATHER: Thomas McGuinness

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland.

12 MAIDEN NAME OF MOTHER: Margaret McCann

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Londonderry Ireland.

14 Informant: Marjorie McGuinness (Address) 3508 Bank St.

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

4 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 20-1929.

17 I HEREBY CERTIFY, That I attended deceased from June 16. 1929. to June 20. 1929.

that I last saw h[e] alive on June 20 1929.

and that death occurred on the date stated above, at 3 30 P. m.

The CAUSE OF DEATH was as follows: Acute Dilatation Heart.

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Heart Hypertension

(duration) yrs. mos. 3½ ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical Examination.

(Signed) C. E. McCausland M. D.

6/24. 1929 (Address) 3508 Bank St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Has been

DATE OF BURIAL: 6/25 19 29

20 UNDERTAKER: J. A. Moran

ADDRESS: 300 E Baltimore

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47118 90 ✓ **E 47118**

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 4101 Frisby St., 9-47 Ward)

2-FULL NAME Katie Henderson

(a) RESIDENCE NO. 4101 Frisby St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred / yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F	W	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Henderson

6 DATE OF BIRTH (month, day, and year) June 18/1883

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	46	0	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Middletown, Md

PARENTS

10 NAME OF FATHER Harry Crone

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Middletown, Md.

12 MAIDEN NAME OF MOTHER Mary Firestone

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Middletown, Md

14 Informant Mercedes Snurr
(Address) Middletown, Md.

15 Filed C. HAMPSON JONES, M. D. Registrar

241929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22/29

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Bullen, M. D.

19 (Address) 300 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Fredrick Pa	6/25/29
20 UNDERTAKER J. J. Doran	ADDRESS 306 E Beatty

Be sure the right terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47119

CERTIFICATE OF DEATH

E 47119

REGISTERED NO. 28-65

1—PLACE OF DEATH St Joseph Hospital

CITY OF BALTIMORE: (No. St. Joseph Hospital ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lillie Kuruss

(a) RESIDENCE NO. 3833 Fendale ST. Road WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 15 1888

7 AGE: Years 41 | Months 1 | Days 7 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Bookbinder

(b) General nature of industry, business, or establishment in which employed (or employer): Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Chas. Fitzburg

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Agnes J. Cole

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Marie Kornberger

(Address) 3827 Fendale Ave

15 Filed 6/24/29, 19 HAMPSON JONES, M. D. Registrar

24923

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/23/29

17 I HEREBY CERTIFY, That I attended deceased from 6/17/29, 19..., to 6/23/29, 19...

that I last saw h... alive on 6/23/29, 19...

and that death occurred, on the date stated above, at 11.05 A m.

The CAUSE OF DEATH* was as follows:

subacute endocarditis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) septicemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 6/18/29 Removal of Tonsils

Was there an autopsy? No

What test confirmed diagnosis? Clinical Course

(Signed) W. H. Lundeen M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount

DATE OF BURIAL: 6/27/29

20 UNDERTAKER: J. G. Brown

ADDRESS: E Balto

Spec.—2-29-28—L. F. S.—500 Bks.

E 47120

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-002

E 47120

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 410 (STREET) Sanders (WARD) 24-33

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thomas H. Starr

(a) RESIDENCE NO. 410 (Usual place of abode) Sanders ST., WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 5yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Ellen Morgan Starr

6 DATE OF BIRTH (month, day, and year): Jan 31, 1845

7 AGE: Years 84 Months 4 Days 23 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs Mary T. Sayer

(Address) 410 Sanders St

15 24 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 23-1929

17 I HEREBY CERTIFY, That I attended deceased from May 3 1928, to June 23 1929.

that I last saw h[illegible] alive on June 23 1929

and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Cirrhosis Sclerosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) C. Wheeler, M. D.

6/29, 1929 (Address) 1299 Millcam St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: June 25 1929

20 UNDERTAKER: Margaret E. Flynn — ADDRESS: 14 W Lexington St

Spec.—I-10-21—M&T—1500 Bks.

E 47121

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47121

CERTIFICATE OF DEATH.

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 52 East 32nd St.) (WARD) 12-50

2-FULL NAME James Albert Gordy

(a) RESIDENCE No. 152 East 32nd ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Leonora M. Gordy

6 DATE OF BIRTH (month, day, and year) July 22, 1860

7 AGE Years 69 Months 11 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Coal Dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pittsburgh Pa

PARENTS

10 NAME OF FATHER William Carson Gordy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pittsburgh Pa

12 MAIDEN NAME OF MOTHER Margaretta Ligertwood

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pittsburgh Pa

14 Informant Mrs Leonora M. Gordy

(Address) 152 East 32nd St

15 Filed 1929

C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22nd 1929

17 I HEREBY CERTIFY, That I attended deceased from July 1928 to June 22 1929

that I last saw him alive on June 21 1929

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis

about (duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. L. Leonard M. D.

19 (Address) 520 N. Paca St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parsons Cemetery Salisbury Md DATE OF BURIAL 6-25-29

20 UNDERTAKER H C Brammer Sons Salisbury Md ADDRESS 1130

241929

TION is very important. See instructions on back of certificates. Exact statement of OCCUPA-

Spec.—2-29-28—L. F. S.—500 Bks.

E 47122

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

111-001

E 47122

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Balt. City Hosp ST. 6-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Nathan Mitchell

(a) RESIDENCE NO. 220 N. Bethel ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married, Widowed or Divorced~~, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of 0

6 DATE OF BIRTH (month, day, and year) Oct. 17, 1898

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	31			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Nathan Mitchell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Anthony

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hosp. Record
(Address)

15 4-1923 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/23/29

17 I HEREBY CERTIFY, That I attended deceased from 3/2, 1929, to 6/23, 1929, that I last saw him alive on 6/23, 1929 and that death occurred, on the date stated above, at 4^00 a. m.

The CAUSE OF DEATH* was as follows:

Gastric ulcer

... (duration) Unknown mos. ds.

CONTRIBUTORY (Secondary) Broncho pneumonia

... (duration) ... yrs. ... mos. 4 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? yes Date of 3/17/29

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. H. Humphris, M. D.

6/23, 1929 (Address) Balt. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Evergreen Cemetery	6/25 1929
20 UNDERTAKER	ADDRESS
Thos. & Chas. G. Conley	1421 Jefferson St

Spec.—2-29-28—L. F. S.—500 Bks.

E 47123

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47123

1—PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO. 90 15-21

CITY OF BALTIMORE: (No. ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Johnson

(a) RESIDENCE NO. 1516 N. Stockton ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., If foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
62			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Records of

(Address) Baltimore City Hospitals

15 241929 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 19, 1929

17 I HEREBY CERTIFY, That I attended deceased from February 15, 1925, to June 19, 1929,

that I last saw him alive on June 19, 1929

and that death occurred, on the date stated above, at 5:20 P m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic

over (duration) / yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis, Hemiplegia, Old

over (duration) / yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Marion A. McClure, M. D.

6-20, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart	6/24, 1929
20 UNDERTAKER	ADDRESS
John J. Feher Sons	1318 Light St

Spec.—1-10-21—M&T—1500 Bks.

E 47124 HEALTH DEPARTMENT—CITY OF BALTIMORE **E 47124**

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) U.S. Marine Hospital (ST.) 2-4 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emelio Garostola

(a) RESIDENCE NO. 1627 Thames St., Balto., Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State) Spain

Length of residence in city or town where death occurred yrs. mos. 3 ds. How long in U. S., if of foreign birth? unknown mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 30, 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32	10	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Oiler

(b) General nature of industry, business, or establishment in which employed (or employer) Seaman

(c) Name of employer S.S. "Santa Eulalia"

9 BIRTHPLACE (city or town) (State or country) Spain

PARENTS

10 NAME OF FATHER Esidio Garostola

11 BIRTHPLACE OF FATHER (city or town) (State or country) Spain

12 MAIDEN NAME OF MOTHER Andresa Lartadegui

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Spain

14 Informant Records, U.S. Marine Hospital (Address)

15 Filed 2-4-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22 19 29

17

I HEREBY CERTIFY, That I attended deceased from June 21, 19 29, to June 22, 19 29, that I last saw him alive on June 22, 19 29, and that death occurred, on the date stated above, at 8.25 P m.

The CAUSE OF DEATH* was as follows:

Gastric ulcer, perforated

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Acute general peritonitis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of June 21, 1929

Was there an autopsy? No

What test confirmed diagnosis? Physical examination & operation

(Signed) C. E. Wilmot M. D.

6/24, 19 29 (Address) U.S. Marine Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Mary's, Hampden — DATE OF BURIAL June 25, 19 29

20 UNDERTAKER E. Leroy Stiffler Inc. — ADDRESS 125 E. North Ave.

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47125

CERTIFICATE OF DEATH

E 47125

1—PLACE OF DEATH

REGISTERED NO. 17-76 25-581

CITY OF BALTIMORE: (No. 700 Edmondson Ave. ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William J. Wilson,

(a) RESIDENCE NO. 700 Edmondson Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) December ? 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69	6		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Coach Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Matthew Wilson,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Rebecca Morehead,

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Miss Eva Wilson
(Address) 700 Edmondson Ave

15 Filed ....., 19 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY, That I attended deceased from about 2 years —, 19...., that I last saw h/mt alive on Friday June 21, 1929 and that death occurred, on the date stated above, at 10 55 P m.

The CAUSE OF DEATH* was as follows:

Hemiplegia

duration 2 yrs. — mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Signs & symptoms

(Signed) William B. Rich, M. D.

June 24, 1929 (Address) Quincy Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL 19

20 UNDERTAKER P. Gan Little ADDRESS

Spec.—12-9-25—A Co.—200 Bks.

E 47126

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

127-02 E 47126

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1131 W Hamburg St., 21-29 Ward)

2-FULL NAME Joseph Strobeck

(a) RESIDENCE NO. 1131 W Hamburg St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 31 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word)
M	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) ~~WIFE of~~ Lena Strobeck

6 DATE OF BIRTH (month, day, and year) 1860 8 28

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	68	10	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Tin Mfg Co.

9 BIRTHPLACE (city or town) Austria

(State or country)

PARENTS

10 NAME OF FATHER Frank Strobeck

11 BIRTHPLACE OF FATHER (city or town) Austria

(State or country)

12 MAIDEN NAME OF MOTHER Marie Lochmann

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Austria

14 Informant Mrs Joseph Strobeck

(Address) 1131 W Hamburg St

Filed C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6.23, 1929

17 I HEREBY CERTIFY, That I attended deceased from 6/10, 1929, to 6.23, 1929, that I last saw h~~im~~ alive on 6.23, 1929, and that death occurred, on the date stated above, at 11.10 a.m.

The CAUSE OF DEATH* was as follows:

Myocarditis

Immediate (duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Ascites from Cirhosis

From History (duration) yrs. 1 mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirm diagnosis?

(Signed) E. J. Burlington, M. D.

, 19 (Address) 102 E Hoffman

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Date of Burial June 26 1929

20 UNDERTAKER Fu Co. ADDRESS 1117 N Broadway

Very important. See instructions on back of certificates. Exact statement of OCCUPATION is

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47127 E 47127

CERTIFICATE OF DEATH.

101-09

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) St. Agnes Hospital (ST.) W. North (WARD) 11-29

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Rainer.

(a) RESIDENCE NO. 1311 Kuper st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 COLOR OR RACE: White

5 Single, ~~Married~~, Widowed, or ~~Divorced~~, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Jessie

6 DATE OF BIRTH (month, day, and year): Oct 4 1860

7 AGE: Years 68 Months 8 Days 7 If LESS than 1 day, hrs. or min.

69

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): La Plata Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): La Plata Md

14 Informant: Mrs Wm Farrington (Address) 780 Hanover Blvd

15 Filed: 1929 C. HAMPSON JONES, M. D. Registrar

P.M. 10 A.M.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 23 1929

17

I HEREBY CERTIFY, That I attended deceased from June 21. 1929. to June 23 1929.

that I last saw him alive on June 23 1929.

and that death occurred, on the date stated above, at 10.40 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical.

(Signed) Nicholas J. Daniello M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: June 27 1929

20 UNDERTAKER: Wm Cole — ADDRESS: 1417 St Paul

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47128

90 **E 47128**

REGISTERED NO. 17-51

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2616 Maryland ~~St.~~ Ave WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary A. DonLevie

(a) RESIDENCE NO. 2616 Maryland ~~St.~~ Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Austin DonLevie

6 DATE OF BIRTH (month, day, and year) Feb 21, 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	4	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Louis Wonder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Europe

12 MAIDEN NAME OF MOTHER Matilda Harrison

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Europe

14 Informant Austin DonLevie Jr.

(Address) 2616 Maryland Ave

15 Filed 24523 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22, 1929

17 I HEREBY CERTIFY, That I attended deceased from 2/22/29, 19..., to 6/22/29, 19..., that I last saw h[illegible] alive on 6/22/29, 19... and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Ch. Endocarditis

(duration) 1½ yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H. Gaddes, M. D.

6/24/29 (Address) 321 E 25

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	June 26 1929

20 UNDERTAKER Wm Cook ADDRESS 1217 St Paul St

Spec.—2-29-28—L. F. S.—500 Bks.

E 47129

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-081

E 47129

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 500 N. Madeira ST. 1-3 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Sing

(a) RESIDENCE NO. 560 N. Madeira ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 6 mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of John Sing

6 DATE OF BIRTH (month, day, and year) Aug 20 - 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	75	10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Mary Hagner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto

14 Informant Mrs. Mary Sing
(Address) 560 N. Chester St

15 Filed JUN 24 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22 29

17 I HEREBY CERTIFY, That I attended deceased from May 22 19 29 to June 22 19 29

that I last saw h[illegible] alive on June 22 19 29

and that death occurred, on the date stated above, at 8 30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Cardiac Paralysis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J. Sauer M. D.

19 Address 1 W. Madison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Loudon Park Cemetery	June 25 1929

20 UNDERTAKER Chas E. Miller & Son ADDRESS 2334 Jeffer[illegible] St

Spec.—1-10-21—M&T—1500 Bks.

226330

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47130

CERTIFICATE OF DEATH. X 84

E 47130

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 1-9 WARD)

2-FULL NAME Dr Henry S. Persons

(a) RESIDENCE NO. Montgomery Ala. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ala

PARENTS

10 NAME OF FATHER J. W.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ga

12 MAIDEN NAME OF MOTHER E Persons

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ala

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUN 25 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24 1929

17 I HEREBY CERTIFY, That I attended deceased from June 16, 1929, to June 24, 1929, that I last saw him alive on June 24, 1929, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Brain tumor, benign

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Broncho-pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of June 21, 1929 Removing tumor

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) Ridgeway Trimble M. D.

June 24 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Montgomery Ala DATE OF BURIAL June 25 1929

20 UNDERTAKER John E Pritchett ADDRESS 190 Eutaw

N 23 1929 HAMPSON JONES, M. D. Registrar

THIS is very important. See instructions on back of certificates.

important. See instructions on back of certificate. Exact statement of OCCUPATION is very

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47131 F DEATH

E 47131
REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of Baltimore: (No. 1318 Linden Ave St. 11-24 Ward)

2-FULL NAME Harriet Ribeon Freeman

(a) RESIDENCE NO. 1318 Linden Ave St., Ward
(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. 7 mos. 2 ds. (If non-resident give city or town and State)
How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 Color or Race: White
5 Single, Married, Widowed or Divorced, (write the word): Divorced
5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Freeman
6 DATE OF BIRTH (month, day, and year): 1884 - Nov 19
7 AGE: Years 44 Months 7 Days 2 IF LESS than 1 day ..... hrs. or ..... min.
8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Nurse
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer
9 BIRTHPLACE (city or town): Elkridge.
(State or country)

PARENTS

10 NAME OF FATHER: [illegible]
11 BIRTHPLACE OF FATHER (city or town)
(State or country)
12 MAIDEN NAME OF MOTHER: Elizabeth [illegible]
13 BIRTHPLACE OF MOTHER (city or town): Md.
(State or country)

14 Informant: Henry E. Epley
(Address) 349 S. Eutaw St.

15 Filed ..... C. HAMILTON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) about June 21st 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Hypostasis (duration) ..... yrs. Sudden dy
CONTRIBUTORY (Secondary)
..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? House
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis?
(Signed) [illegible] Regular Physician Coroner. M. D.
(Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem. DATE OF BURIAL 6/25 1929
20 UNDERTAKER: Harry N. Armacost ADDRESS 4204 Reisterstown Rd.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47132

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

15-002

E 47132

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 634 Gorsuch Ave ST., 9-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emma Lavinia Aitken Philips

(a) RESIDENCE NO. 634 Gorsuch Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 85 yrs. 0 mos. 0 ds. How long in U. S., if foreign birth? 85 yrs. 0 mos. 0 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: John Philips

6 DATE OF BIRTH (month, day, and year): Nov. 6-1840

7 AGE — Years: 88 | Months: 7 | Days: 17 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Manchester England

PARENTS

10 NAME OF FATHER: Edw. B. Jackson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Manchester England

12 MAIDEN NAME OF MOTHER: Anne Williamson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Manchester England

14 Informant: Mrs Jane A. Prentiss (daughter)

(Address) 634 Gorsuch Ave.

15 JUN 25 1929 HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 23-29

17 I HEREBY CERTIFY, That I attended deceased from about 20 Jun 19 to June 23 19 29 that I last saw h alive on June 23 19 29 and that death occurred, on the date stated above, at 7-50 a m.

The CAUSE OF DEATH* was as follows:

Coma is Paraplegia

(duration) about 26 yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at Place of death

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? —

(Signed) H. E. Prentiss, M. D.

6-22-1929 (Address) 634 Gorsuch Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Johns - (Waverly) | DATE OF BURIAL: June 25 1929

20 UNDERTAKER: Elwood Mowen Co | ADDRESS: Balto

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

E 47133

12-002

12 E 47133

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 3131 Hanover ST., 25-74 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Andrew Bruning

(a) RESIDENCE No. 3131 Hanover ST., ... WARD .....

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 61 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	W	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Carolina Bruning

6 DATE OF BIRTH (month, day, and year) Aug 18 1867

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
61	10	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Boatman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER George Bruning

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Hagen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Carolina Bruning

(Address) 1528 Covington st

251929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22nd 1929

17 I HEREBY CERTIFY, That I attended deceased from April 26th, 1929, to June 22nd, 1929.

that I last saw him alive on June 22nd, 1929.

and that death occurred, on the date stated above, at 12 25 p.m.

The CAUSE OF DEATH* was as follows:

Chronic cirrhosis of the liver

(duration) — yrs. 1 mos 27 ds.

CONTRIBUTORY (Secondary) Anemia

(duration) ..... yrs. ..... mos. 10 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X ray & physical findings

(Signed) Otto Lebbel M. D.

6/22, 1929 (Address) 1227-26 Hanover St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill — DATE OF BURIAL June 25 1929

20 UNDERTAKER John F Denny — ADDRESS 1515 14 St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47134
1-PLACE OF DEATH

CERTIFICATE OF DEATH

182 ✓

E 47134
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of Baltimore: (No. Off Consolidation Coal Pier St; Loc. 24-35 Point.

2-FULL NAME Bromslaw Paszkowski.

(a) RESIDENCE NO. 1114 Haubert St. St., Ward
(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. ---- mos. ---- How long in U. S., if of foreign birth 20 yrs. ---- ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	48	----------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Stevedore.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Poland.
(State or country)

PARENTS

10 NAME OF FATHER Frank Paszkowski

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland.

12 MAIDEN NAME OF MOTHER Julia ----------

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland.

14 Informant Michael Paszkowski. (brother)
(Address) 860 Concord St. Pittsburg. Pa.

Filed ..... 19 ..... C. HARRISON JONES, M. D. Registrar

251929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:
Accidental Drowning. while in swimming.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto H. Leinhardt, M. D.

6/24, 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cem — DATE OF BURIAL June 26 1929

20 UNDERTAKER Chas. A. Sherwin — ADDRESS 1591 E Fort Ave

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47135

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

4 E 47135

1—PLACE OF DEATH 2744

CITY OF BALTIMORE: (No. Annapolis ST. 425-32 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Fannie Blake

(a) RESIDENCE NO. 711 Vinson ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1871

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework, 20

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Scott Phippins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Mrs. Mary Thomas

(Address) 2448 Annapolis Rd

15 Filed ..., 19 ... Registrar

SIGNATURE OF REGISTRAR JONES, M. D.

N 251928

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/27/29

17 I HEREBY CERTIFY, That I attended deceased from 5/18/29, to 6/27/29, 19 29

that I last saw h[illegible] alive on 6/27/29, 19 29

and that death occurred, on the date stated above, at 9 A.M.

The CAUSE OF DEATH* was as follows:

Cause of Stomach

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Gastritis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

, 19 (Address) 727 Ashburton

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	6-25 1929
20 UNDERTAKER Daniel Easton	ADDRESS 916 Ba ave

Cor.—10-10-29—A Co.—100 Bks.

E 47136

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47136

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 645 Pierce St. 17-25 Ward)

2-FULL NAME Martha Wright

(a) RESIDENCE NO. 645 Pierce St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Negro	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	58			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Rob Lacey
(Address) 645 Pierce St.

15 Filed ....., 19.. C. HAMILTON JONES, M. D.
Registrar

251929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zeller, M. D.

6/27 1929 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
MT Auburn Cem	6-25 1929
20 UNDERTAKER	ADDRESS 816 Ea ave
D Lent Eaton	

important. See instructions on back of certificate.

Spec.—I-10-21—M&T—1500 Bks.

22461 6
E 47137

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 47137

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 17-24 WARD)

2-FULL NAME Elsie Chatman

(a) RESIDENCE No. 416 Orchard ST., ... WARD
(Usual place of abode)
Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F | 4 COLOR OR RACE C. | 5 Single, Married, Widowed, or Divorced, (write the word) Female

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 11/18/29

7 AGE Years | Months 5 | Days 4 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) ... Md
(State or country)

PARENTS

10 NAME OF FATHER Geo.

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Elsie Thomas

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

Filed JUN 25 1929, 19 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22 1929

17

I HEREBY CERTIFY, That I attended deceased from Apr 22, 1929, to June 22, 1929, that I last saw her alive on June 22, 1929, and that death occurred, on the date stated above, at 7.45 P m.

The CAUSE OF DEATH* was as follows:
1. Bilateral bronchopneumonia
Bilateral empyema

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Chronic pneumonia

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) George F. Emmert, M. D.

June 23, 1929 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem | DATE OF BURIAL 6/25/29

20 UNDERTAKER Samuel Newsham & Biddle | ADDRESS 1258

TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47138

CERTIFICATE OF DEATH

198 **E 47138**

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St., 14-28 Ward)

2-FULL NAME Charles E. Carney

(a) RESIDENCE NO. 302 S. Stricker St., Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Beatrice Carney

6 DATE OF BIRTH (month, day, and year) Oct. 6-1904

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	24	8	17	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Chauffeur
(b) General nature of industry, business, or establishment in which employed (or employer) Self
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Md

PARENTS

10 NAME OF FATHER Albert Carney

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Md

12 MAIDEN NAME OF MOTHER Mary E. Chenowith

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Md

14 Informant (Address) Mary E. Bush (Mother) 302 S. Stricker St.

15 Filed ....., 19 ..... C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Stab wound of chest
Homicide

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Hemorrhage

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? 652 W. Balto St.

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) Eugene Zellers, M. D.

6/25, 1929. (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Stone Chapel Cem	June 26th 1929
20 UNDERTAKER D. A. Jones	ADDRESS W. S. Gilmor

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47139

46

CERTIFICATE OF DEATH

E 47139

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 23-31 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary E Wilkens

(a) RESIDENCE NO. 125 W. Cross ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
~~HUSBAND of~~
(or) WIFE of Geo Wilkens

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) ?
(State or country) Md.

PARENTS

10 NAME OF FATHER Thomas Mack

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) Germany

14 Informant Friends
(Address) BALTIMORE CITY HOSPITALS

15 Filed 1929 C. HAMPSON JONES, M. D.
(Registrar)

125102

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-23-29

17 I HEREBY CERTIFY, That I attended deceased from 11-20, 1928, to 6-23, 1929, that I last saw her alive on 6-23, 1929 and that death occurred, on the date stated above, at 6:2 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma Cervix, Dt.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Secondary Anemia

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Sign

(Signed) Warren H. McLean, M. D.

, 19 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	June 26 1929
20 UNDERTAKER Gorsuch Cowen & Son	ADDRESS 901 Eutaw St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47140

CERTIFICATE OF DEATH

129 E 47140

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1010 N. Wolfe ST. 7-13 WARD)

2—FULL NAME Geo. W. Coleman Jr.

(a) RESIDENCE NO. 1010 N Wolfe ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Married

a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mary E. Coleman

6 DATE OF BIRTH (month, day, and year) Feb 28 1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	56	3	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stevedore

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Geo W. Coleman Sr.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Katie Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs Mary E. Coleman (wife)

(Address) 1010 N. Wolfe St.

15 Filed 19 [redacted]SON JONES, M. D. Registrar

125129

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23, 1924

17 I HEREBY CERTIFY, That I attended deceased from May 18, 1924, to June 23 1924, that I last saw h[illegible] alive on June 22, 1924 and that death occurred, on the date stated above, at 2 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis and Arteriosclerosis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) R. Yeatman, M. D.

6/24 1924 (Address) 1424 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL: June 26 1924

20 UNDERTAKER — ADDRESS: 1815 McElderry

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47141

CERTIFICATE OF DEATH

129 E 47141

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 207 N. Mount St. ST. 14-27 WARD)

2—FULL NAME Mary E. Colwell

(a) RESIDENCE NO. 207 N. Mount St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

a If married, widowed, or divorced HUSBAND of (or) WIFE of William Colwell

6 DATE OF BIRTH (month, day, and year) March 1, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	3	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife Keeper

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER Cato Prann

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Hannah Smith

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

14 Informant Mable Warfield
(Address) 1308 W. Franklin St.

15 Filed 25 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 3, 1929 to June 22, 1929, that I last saw her alive on June 22, 1929 and that death occurred, on the date stated above, at 9;25 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nrphritis

(duration) yrs. 3 mos. 19 ds.

CONTRIBUTORY (Secondary) Mitral Insuficiency

(duration) yrs. 3 mos. 19 ds.

18 Where was disease contracted if not at place of death? At place o f death

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) Walter J. Jackson, M. D.

, 19 (Address) 1631 W. Franklin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery

DATE OF BURIAL June 25, 1929

20 UNDERTAKER Mrs Katie R. Williams

ADDRESS 3221 Schroeder St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47142 74-001 **E 47142**

REGISTERED NO. 6-10

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 416 Duncan ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank Strycelar (Stucber)

(a) RESIDENCE NO. 416 Duncan ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if foreign birth? 36 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Strycelar

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Bell Foundry

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austro Hungarian

PARENTS

10 NAME OF FATHER Frank Strycelar

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austro Hungarian

12 MAIDEN NAME OF MOTHER Anna Duncka

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austro Hungarian

14 Informant Anna Strycelar
(Address) 416 N Duncan St

15 Filed 25 1928 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24/29

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1929, to June 24, 1929

that I last saw h— alive on June 24, 1929

and that death occurred, on the date stated above, at 3:45 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 9 ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. L. Reese M. D.

(Address) 806 N Kenwood Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	June 26 1929
20 UNDERTAKER	ADDRESS
Frank Woodson	1906 Eastwood Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47143 100-002 E 47143

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 211 S. Bentalou ST. N-69 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME June E. K. Mc. Knew

(a) RESIDENCE NO. 211 S. Bentalou ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 4 mos. 8 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: —

6 DATE OF BIRTH (month, day, and year): Feb 15th 1928

7 AGE: Years 1 | Months 4 | Days 8 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (City or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Leroy J. F. Mc. Knew

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Catherine Seymour

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 INFORMANT: Leroy J. F. Mc. Knew
(Address) 211 S Bentalou St

15 FILED JUN 25 1929 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 23/29

17 I HEREBY CERTIFY, That I attended deceased from June 18, 1929, to June 23, 1929, that I last saw h alive on June 23, 1929, and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Toxaemia + Convulsions 5 hours
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Epilepsy Convulsions
(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Howard Kahn M. D.

6/25 1929 (Address) 3027 N Paca St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: June 27th 1929

20 UNDERTAKER: H. O. Weisheit

ADDRESS: 1850 W Balto St

Spec.—2-29-28—L. F. S.—500 Bks.

E 47144

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

#6

E 47144

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 523 S. Caroline ST. 3-4 WARD)

2—FULL NAME Jennie Schriver

(a) RESIDENCE NO. 523 S. Caroline ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Martin Schriver

6 DATE OF BIRTH (month, day, and year) Not Known.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69.	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) Work.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Schriver

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore

12 MAIDEN NAME OF MOTHER Not Known.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Barta Hyssett

(Address) 523 S. Caroline St.

15 Filed Apr 30 1929 HARRISON JONES, M. D. Registrar

251929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) April 23. 1929.

17 I HEREBY CERTIFY, That I attended deceased from April 23, 1929, to May 1, 1929, that I last saw h[illegible] alive on June 20, 1929, and that death occurred, on the date stated above, at 3 9 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of cervix uteri

Metastasis to liver

Traumatic stricture of rectum

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cachexia

(duration) yrs. mos. ds.

Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) Andrew Sheary, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenlawn Cemetery DATE OF BURIAL 4/25/29

20 UNDERTAKER Wendell Haspel ADDRESS 320 S Eden.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47145 — 1—PLACE OF DEATH

E 47145 — REGISTERED NO.

CITY OF BALTIMORE; (No. 1332 Lawson St ST. 2435 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John J Sonkilor

(a) RESIDENCE NO. 1332 Lawson St ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. 1 mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Dec 2. 1851

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	77 78	6	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer) Shipwork

(c) Name of employer Balto Steam Ship Co

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Sonkilor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Mrs Ella Mosley

(Address) 1336 Lawson St

15 Filed ... 19... C. HAMPSON JONES, M. D. Registrar

N 25 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24 1929

17 I HEREBY CERTIFY, that I attended deceased from Jun 23, 1929, to Jun 24, 1929

that I last saw h~~e~~ alive on Jun 24, 1929

and that death occurred, on the date stated above, at 9:20 a m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

Senility

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Edema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) R. L. Campbell M. D.

June 26, 1929 (Address) 1644 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount

DATE OF BURIAL Jun 27 1929

20 UNDERTAKER Chas L Stevens

ADDRESS 1537 E Fayette

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47146

CERTIFICATE OF DEATH.

E 47146

REGISTERED NO. 27-42

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 5600 Hilltop Ave St.) (Ward)

2-FULL NAME Andrew Wamp

(a) RESIDENCE NO. 67 W High St Gettysburg Pa Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 16 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine (Wampler) Wamp

6 DATE OF BIRTH (month, day, and year) Sept 12 1844

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	84	9	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Gardener

(c) Name of employer Gettysburg

9 BIRTHPLACE (city or town) Pennsylvania

(State or country)

PARENTS

10 NAME OF FATHER Wampler

11 BIRTHPLACE OF FATHER (city or town) Germany

(State or country)

12 MAIDEN NAME OF MOTHER Wampler

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Parker Wampler (Nephew)

(Address) 5600 Hilltop Ave

Filed ..... 19 ..... H. HAMILTON JONES, M. D. Registrar

Per .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Apoplexy

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) J. H. Wilson M. D.

(Coroner)

6/25 1929 (Address) 508 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?.....

Former or usual residence.....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Evergreen Cemetery Gettysburg Date of Burial June 27 1929

20 UNDERTAKER H. C. Bender & Son ADDRESS Gettysburg

J. M. 03,

If not entirely filled in, this certificate may be returned for correction. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 47147 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47147

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1122 Lafayette Ave ST. 16-25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Thomas

(a) RESIDENCE NO. 1122 Fayette Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 28 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State) New York.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	C	M.

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Loyd Thomas

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
48			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Nelson Co (State or country) Va

PARENTS

10 NAME OF FATHER Harry Cole

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mary Cole

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Harry Cole

(Address) 1121 Lafayette Ave.

15 Filed 6/25/29 H. McCOY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23, 29

17 I HEREBY CERTIFY, That I attended deceased from June 11, 1929, to June 23, 1929

that I last saw h[illegible] alive on June 22, 1929

and that death occurred, on the date stated above, at 10 00 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. N. Hatcher, M. D.

6/25, 1929 (Address) 1115 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cem	6/24/1929
20 UNDERTAKER Dyson Wrights	ADDRESS 219 Mt Holly

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47148

1-PLACE OF DEATH

City of Baltimore: (No. 615 Hilton St. 16-67 Ward)

2-FULL NAME Catherine B. Kelley.

(a) RESIDENCE NO. 615 Hilton St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. 11 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

E 47148

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced: HUSBAND of (or) WIFE of John J. Kelley

6 DATE OF BIRTH (month, day, and year) July 12 1858

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	70	11	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment: in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Jas Brannan

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Catherine Dowan

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant Mrs. Ward H. Reese
(Address) 1534 Riverside

15 Filed JUN 25 1929 HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23rd 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.
The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
(duration) Long — yrs. — mos. — ds.

CONTRIBUTORY (Secondary)
(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Regular
(Signed) Jno. J. Kelleher, M. D.
(Address) June 23 1929 Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL June 26 1929

UNDERTAKER Margaret E. Hynes — ADDRESS 4 W Biddle St

important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47149 168 ✓ **E 47149**

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1312 James St. 21-29 Ward)

2-FULL NAME Alfred Huber

(a) RESIDENCE NO. 1310 James St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Alice Huber

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	53	-	-	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tailor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Russia
(State or country)

PARENTS

10 NAME OF FATHER Julius Huber

11 BIRTHPLACE OF FATHER (city or town) Russia
(State or country)

12 MAIDEN NAME OF MOTHER Eva Strunk

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Mrs. Alfred Huber
(Address) 1310 James

15 Filed ..... 19... E. HAMPSON JONES, M. D. Registrar

N 251929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

(a) Suicide by Hanging

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. H. Brown, M. D.

June 24, 1929 (Address) 3601 Brdwy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Matthai Cemetery — DATE OF BURIAL June 26 1929

20 UNDERTAKER Margolet & Hyman — ADDRESS 1422 Bright

This certificate is to be filled in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 47150 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47150

CERTIFICATE OF DEATH.

31

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2115 Allendale Rd ST., ... WARD) 15-61

2-FULL NAME Howard Claiborne Harris

(a) RESIDENCE NO. 2115 Allendale Road ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. 5 mos. 8 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, Widowed, ~~or Divorced, (write the word)~~
M	W.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 16-1903

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	26	5	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer) Insurance

(c) Name of employer New England Mutual Balto

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Fred J. Harris

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Maggie McClaiborne

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Fred J. Harris
(Address) 2115 Allendale Road

15 Filed ..... 19..... C. HAMPSON JONES, M. D.
By ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24th 1929

17 I HEREBY CERTIFY, That I attended deceased from May-29, 1929, to June 24, 1929, that I last saw him alive on June 24 1929 5.30 P. m. and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 3 yrs. — mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Wesley Cole M. D.

7/25 1929 (Address) 2207 Druid Park Drive

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cemetery	June 27th 1929
20 UNDERTAKER	ADDRESS
Latrams & Gore	1723 W. Lafayette Ave

FOR is very important. See instructions on back of certificates.

Spec.—8-24-14—M. & T.—2000 Bks.

E 47151 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47151

CERTIFICATE OF DEATH.

24-001

1-PLACE OF DEATH Sunday Sanitarium REGISTERED NO. C

CITY OF BALTIMORE: (No. Alfred Frances Road ST. 28-7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mrs Julia Constance Watts

(Residence in Baltimore: No. Sunday Sanitarium St.; — yrs. — mos. 5 da.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.) Widow

6-DATE OF BIRTH, Feb. (Month) 18 (Day) 1863 (Year)

7-AGE, 64 yrs. 4 mos. 6 da. If LESS than 1 day, ...hrs. or.....min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work School Teacher
(b) General nature of industry, business, or establishment in which employed (or employer)

9-BIRTHPLACE, (State or Country). Baltimore Md

PARENTS.

10-NAME OF FATHER, Theodore Constance

11-BIRTHPLACE OF FATHER (State or Country), Baltimore Md

12-MAIDEN NAME OF MOTHER Mary Seely

13-BIRTHPLACE OF MOTHER (State or Country), Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mary L Constance

(Address) 119 Osborne Ave

15- Filed ....., 191.... C. HAMPSON JONES, M. D. Registrar.

281379

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, June (Month) 24 (Day), 1919 (Year)

17- I HEREBY CERTIFY, That I attended deceased from June 19 1919, to June 24 1919, that I saw h.. alive on June 24 1919, and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Cerebro Nephritis

Almost (Duration) ....yrs. ....mos. ....da.

CONTRIBUTORY (Secondary) Cerebro Hemorrhage

(Duration) ....yrs. ....mos. ....da.

(Signed) Wilbur T. Grimes M. D.

June 24., 1919. (Address): Alfred Frances Road

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death ....yrs. ....mos. 5 da. In the State Almost yrs. ....mos. ....da.

Where was disease contracted, if not at place of death?

Former or usual residence Brooklyn N. Y.

19-PLACE OF BURIAL OR REMOVAL, Evergreen Cemetery Brooklyn N.Y. DATE OF BURIAL, June 26, 1919

20-UNDERTAKER Wm Cook 1217 ADDRESS St Paul

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47152

CERTIFICATE OF DEATH

88 E 47152

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 13-20 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Sheradin

(a) RESIDENCE NO. 2068 Linden ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred / yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillian

6 DATE OF BIRTH (month, day, and year) July 27, 1885

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
43	11	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kutztown Pa

PARENTS

10 NAME OF FATHER Wm Sheradin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kutztown Pa

12 MAIDEN NAME OF MOTHER Mary Sheradin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bowers Pa

14 Informant Mrs. Lillian Sheradin

(Address) 2068 Linden ave

15 [illegible] 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-23-29

17 I HEREBY CERTIFY, That I attended deceased from 6-10-29, 19..., to 6-23-29, 19..., that I last saw him alive on 6-23-29, 19..., and that death occurred, on the date stated above, at 6:15 A m.

The CAUSE OF DEATH* was as follows:

(1) Ulcerative endocarditis

(Streptococcus viridans)

(2) Terminal Bronchial Pneumonia

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Blood culture, Clinical course

(Signed) Bryan N. Robertson M. D.

6/23 19 29 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Kutztown Pa

DATE OF BURIAL 6/25 19 29

20 UNDERTAKER J. Hunsicker & Bro

ADDRESS 1127 E Walnut St

Spec.—1-12-23—M&T—500 Bks.

E 47153 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47153

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1300 N Gilmore St., 15-22 WARD)

REGISTERED No.....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Clayton

(a) RESIDENCE No. 1300 N Gilmore ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	Colored	Widower

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of Elizabeth Clayton

6 DATE OF BIRTH (month, day, and year) May 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
	72	1		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St Mary's Co

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Daley Walker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Joseph J Clayton
(Address) 1300 N Gilmore St

15 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-25- 1929

17 I HEREBY CERTIFY, That I attended deceased from 6-17 , 1929 to 6-24 , 1929 ,
that I last saw h— alive on 6-24 , 1929 ,
and that death occurred, on the date stated above, at 5:20A m.
The CAUSE OF DEATH* was as follows:
Cerebral Hemorrhage

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Chron Gastritis
(duration) 1½ yrs. mos. ds.

18 Where was disease contracted if not at place of death? Balto City
Did an operation precede death? no Date of
Was there an autopsy?
What test confirmed diagnosis?

(Signed) Wm R. Boykin M. D.
, 19 (Address) 1512 Gilmore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

UNDERTAKER — ADDRESS

Clarence E Wright 3364 Mar

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47154 E 47154

CERTIFICATE OF DEATH.

REGISTERED NO. 74001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1600 Oliver ST. 8-17 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Jones Chandler

(a) RESIDENCE NO. 1600 Oliver ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Savilla J. Chandler

6 DATE OF BIRTH (month, day, and year): Dec 8-1842

7 AGE: Years 86 Months 6 Days 16 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not known

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not known

14 Informant: Mrs Savilla J. Chandler (Address) 1600 E. Oliver St

15 Filed 25 1929 C. HAMPSON JONES, M. D. Registrar Per NKK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6 24 29 19

17 I HEREBY CERTIFY, That I attended deceased from Aug. 1928, to June 24, 1929, that I last saw him alive on June 21, 1929 and that death occurred, on the date stated above, at 10 15 a m.

The CAUSE OF DEATH* was as follows:

Left Hemaphlegia & Infirmities

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebal Hemorhage

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R. C. Carman, M. D.

6-25, 1929 (Address) 1701 N. Carolina St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cemetery DATE OF BURIAL: June 27, 29

20 UNDERTAKER: Henry Lutz ADDRESS 1203 N. Broadway

TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Blks.

E 47155

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47155

1-PLACE OF DEATH

City of Baltimore: (No. President Hosp. St. 2331 Ward)

REGISTERED NO. 198

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Samuel Wilkes jr.

(a) RESIDENCE NO. 1121 Sharp St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 Color or Race: Col'd | 5 Single, Married, Widowed or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: No.

6 DATE OF BIRTH (month, day and year): May 4 - 1910

7 AGE: Years 19 | Months 4 | Days 18 | IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town): L. C.
(State or country)

PARENTS

10 NAME OF FATHER: Samuel Wilkes Sr

11 BIRTHPLACE OF FATHER (city or town): L. Co.
(State or country)

12 MAIDEN NAME OF MOTHER: Florence Cousey

13 BIRTHPLACE OF MOTHER (city or town): L. Co.
(State or country)

14 Informant: Samuel Wilkes
(Address): 1121 Sharp St

15 Filed ..., 19...

G. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 22nd 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest & Autopsy. (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest & Autopsy (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

(Homicide) 1 day

Hemorrhage due to stab wound of Neck, knife

(duration) ... yrs. ... mos. hour

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? In yard 2134 Montgomery St.

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) Geo. W. Douglas M. D.
Coroner

(Address) 27 Cathedral St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: 6-26-29

20 UNDERTAKER: Wm. T. Easton — ADDRESS: 916 Park Ave

Exact statement of OCCUPATION is very important. See instructions on back of certificate.

25-1929

Spec. 12-29-28—L. F. S.—500 Bks.

E 47156

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

40

E 47156

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Balto City Hosp. ST. 16-22 WARD)

2—FULL NAME Benj. Walkins

(a) RESIDENCE NO. 1515 Winchester ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Jos. Walkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Susan Boolan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hosp. Record
(Address)

15 Filed C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/23/29

17 I HEREBY CERTIFY, That I attended deceased from 6/18, 1929 to 6/23, 1929 that I last saw h[illegible] alive on 6/23, 1929 and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Urethral stricture
Urinary extravasation
Sarcoma, chronic Nephritis
(duration) Unknown mos. ds.

CONTRIBUTORY (Secondary) Toxemia and chronic nephritis (duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of 6/20/29

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) P. M. Livingston, M. D.

6/25, 1929 (Address) Balto City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	6-26 1929
20 UNDERTAKER	ADDRESS 916
Dent Easton	Oz av

Spec.—2-29-28—L. F. S.—500 Bks.

E 47157

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47157

CERTIFICATE OF DEATH

129

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. St Joseph's Hosp ST., 6-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Veronica Czyz

(a) RESIDENCE NO. 109 N. Sutton Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., If foreign birth? 46 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	MARRIED

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anthony Czyz

6 DATE OF BIRTH (month, day, and year) Jan 31 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or.... min.
	51	4	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Andrew Laminski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Rev Stanley Czyz

(Address) 109 N Sutton Ave

15 Filed 251923 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/24/29

17 I HEREBY CERTIFY, That I attended deceased from 6/13, 1929, to 6/24, 1929,

that I last saw h[illegible] alive on 6/24, 1929

and that death occurred, on the date stated above, at 4:30 P.M.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

hypertension

(duration) Mos yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) [illegible], M. D.

6/24, 1929 (Address) St Joseph's Hosp

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cemetery	June 28 1929
20 UNDERTAKER	ADDRESS
John M Weber	401 N Gay St

Spec.—2-29-28—L. F. S.—500 Bks.

E 47158

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

57

E 47158

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No. 1915 Bank St. ST., 2nd WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Agnes Weber

(a) RESIDENCE NO. 1915 Bank St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divoreed, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Weber

6 DATE OF BIRTH (month, day, and year) Jan 21 1867

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	62	5	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife 031

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Michael Koztawski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Hedwig Jakubawska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Rev. Father Joseph A Weber Son
(Address) 1915 Bank St.

15 251929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24 1929

17 I HEREBY CERTIFY, That I attended deceased from March, 1929, to June 24, 1929, that I last saw her alive on June 23, 1929 and that death occurred, on the date stated above, at 1.45 A.m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 3m 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Gangrene - rt. foot

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No - Refused

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Geo. D. Lippy, M. D.

. 19 (Address) 432 S. Patterson Pk. Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	June 27 1929
20 UNDERTAKER	ADDRESS
John N Weber	401 E Chester

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47159 ✓ **E 47159**

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 1118 Haubert ST. 24-25 WARD)

2—FULL NAME Sarah F. Chamberlain

(a) RESIDENCE NO. 1118 Haubert ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of Ransford Chamberlain

6 DATE OF BIRTH (month, day, and year) Dec. 27-1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	5	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER John Owens

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Mrs. Williams

(Address) 1118 Haubert St

15 JUN 25 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23-1929.

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1929 to June 23, 1929

that I last saw him alive on June 23, 1929

and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) Indefinite yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) K. F. Crumbeck M. D.

June 29, 1929 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL 6/26 1929

UNDERTAKER George W. Zirkin — ADDRESS 1737 E Eager St.

Cor.—10-10-29—A Co.—100 Blks.

E 47160

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓ E 47160

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1502 W Franklin St. 14-27 Ward)

2-FULL NAME John Isham

(a) RESIDENCE NO. 1502 W Franklin St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 Color or Race Col

5 Single, Married, Widowed or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Isham

6 DATE OF BIRTH (month, day, and year) Feb 24-1896

7 AGE Years 33 Months 8 Days 25 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Dresser.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) W. Va.
(State or country)

PARENTS

10 NAME OF FATHER Wm Isham

11 BIRTHPLACE OF FATHER (city or town) W Va
(State or country)

12 MAIDEN NAME OF MOTHER Mulkey

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Mary Isham
(Address) 1502 W Franklin

Filed [illegible] 261929 H. HANSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 192 ap

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Mitral Regurgitation
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.
(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	June 26 1929
20 UNDERTAKER	ADDRESS
Mrs. Hattie A. Williams	N. Schroeder Sts

important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 47161

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47161

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: No. 3407 Chestnut Ave ST. 3-52 WARD

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura B. Talbott

(a) RESIDENCE NO. 3407 Chestnut Av ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yr. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Herbert F Talbott

6 DATE OF BIRTH (month, day, and year) Oct 22. 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	38	7	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER John H Wahner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co.

12 MAIDEN NAME OF MOTHER Margaret Russell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co

14 Informant Mr Herbert F Talbott
(Address) 3407 Chestnut Av

15 Filed JUN 26 1929 H. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24 19 29

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1929, to June 24, 1929.

that I last saw her alive on June 24, 19 29

and that death occurred, on the date stated above, at m

The CAUSE OF DEATH* was as follows:

Hemorrhage brain

(duration) ... yrs. ... mos 3 ds.

CONTRIBUTORY (Secondary) Chron Int Nephritis 2 yrs Permission

(duration) 2 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Balto Md

Did an operation precede death? No Date of no

Was there an autopsy? no

What test confirmed diagnosis? clinical

(Signed) J Emmett Kelly, M. D.

6/27 19 29 (Address) 608 Somerset Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudan Park. DATE OF BURIAL June 26 29

20 UNDERTAKER D.S. Marshall ADDRESS 3539 Falls Rd

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47162

CERTIFICATE OF DEATH

100-001

E 47162

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 615 Park ave ST. 11-25 WARD)

2—FULL NAME Josephine Gardner Conkling

(a) RESIDENCE NO. 615 Park Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. 5 mos. 13 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Jan. 11th 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	82	5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Wm H. Conklyn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Conn.

12 MAIDEN NAME OF MOTHER Eliza Gardner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mass

14 Informant Mrs. Annie S. Gephart

(Address) 615 Park ave

15 Filed JUN 26 1929 HAMPSON JONES M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24/29.

17

I HEREBY CERTIFY, That I attended deceased from Jan. 1, 1929, to June 24, 1929.

that I last saw h alive on June 24, 1929.

and that death occurred, on the date stated above, at 6 p m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia -

(duration) yrs. 1 mos. ds.

CONTRIBUTORY — (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At place of death

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? Physical exam.

(Signed) Joseph L. Kelly, M. D.

19 (Address) 1207 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount — DATE OF BURIAL June 26 1929

20 UNDERTAKER Henry H. Jenkins Sons — ADDRESS McCulloh & Eutaw Sts.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47163

CERTIFICATE OF DEATH

90 ✓

E 47163

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. 425 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henreitta Smith

(a) RESIDENCE NO. 643 W. Fairmount Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Unknown

(b) General nature of industry, business, or establishment in which employed (or employer): 87

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Records of

(Address) Baltimore City Hospitals

15 Filed ....., 19 .....

C. HAMPSON JONES, M. D.

Registrar

261929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 23, 1929

17

I HEREBY CERTIFY, That I attended deceased from June 5, 19 29 to June 23, 19 29

that I last saw her alive on June 23, 19 29

and that death occurred, on the date stated above, at 8:10 P. m.

The CAUSE OF DEATH* was as follows:

Hemorrage into pericardium

(contributory removed)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (Chronic)

Myocarditis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home & here

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Marcus M. Allen, M. D.

6-24, 19 29 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn	June 26 1929
20 UNDERTAKER	ADDRESS
Virginia A. Brooks	1463 N. Carey St.

Cor.—10-10-29—A Co.—100 Bks.

E 47164

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 47164

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 24 Redding Court. St. 22-33 Ward)

2-FULL NAME Robert Riley.(C)

(a) RESIDENCE NO. 24 Redding Court. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 48 yrs. 4 mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Married.

5a If married, HUSBAND of (or WIFE of) Annie Riley.(C)

6 DATE OF BIRTH (month, day, and year) February 22, 1881

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	48	4	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer 040

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Solomon Riley.(C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Babe Peach.(C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore, Md.

14 Informant William H. Riley.(C) brother.
(Address) 26 Redding Court.

15 Filed ..., 19... C. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Myocardial Insufficuency.
Acute dilatation of the Heart.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Enquiry

(Signed) Wm. M. Hainard, M. D.

6/25. 19 29 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Ct	June 26 19 29
20 UNDERTAKER	ADDRESS
W. E. Brown & Son	1610 W. Mt.

important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47165

CERTIFICATE OF DEATH

182 E 47165

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Found in Harbor

City of Baltimore: (No. Foot of Lehigh St., 7-13 Ward)

2-FULL NAME Joseph G. Fenwick

(a) RESIDENCE NO. 901 Rutland St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. 2 mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 23/1913

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
+	16	2	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) 040
(c) Name of employer Tubbs Packing Co

9 BIRTHPLACE (city or town) Salt City
(State or country)

PARENTS

10 NAME OF FATHER Robt E Fenwick

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Lucy Travers

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Robert Fenwick
(Address) 901 Rutland ave

15 Filed JUN 26 1929 19 HARRISON JONES, M. D. Registrar
Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Accidental Drowning

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Foot of Lehigh

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James W Hurley, M. D.

6-25 1929 (Address) Tool Chart

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holly Grove Md St Marys — DATE OF BURIAL June 27 1929

20 UNDERTAKER Saml N. Chase Son — ADDRESS 1400 Madison

important. See instructions on back of certificate.

Spec.—6-9-19—H. P. Co.—1000 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47166

CERTIFICATE OF DEATH.

E 47166

6-40

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3115 (St.) Marcco Ave (Ward) 6

2-FULL NAME Joseph Franklin Norris

(a) RESIDENCE. No. 3115 Marcco Ave St., WARD.
(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Eliza Ann Norris

6 DATE OF BIRTH (month, day, and year) Sept 16 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
68 -		9 mths	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 066

(b) General nature of industry, business, or establishment in which employed (or employer) Real Estate

(c) Name of employer Retired

9 BIRTHPLACE (city or town) (State or country) Wakefield Carroll Co. Md.

PARENTS

10 NAME OF FATHER John Norris

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sophie Knight

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mr. Wm C. Norris.
(Address) 2025 Robb St.

15 [illegible] 19

N 261929

C. HARRISON JONES, M.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 19 29

17 I HEREBY CERTIFY, That I attended deceased from June 13 19 29 to June 23 19 29
that I last saw h alive on June 23 19 29
and that death occurred, on the date stated above, at 5.40 P. m.

The CAUSE OF DEATH* was as follows:

Paralysis

(duration) yrs. 10 mos. ds.

CONTRIBUTORY (secondary) Cerebral Hemorrhage (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. Rueckert M.D.

19 (Address) 112 W. 25 St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem. DATE OF BURIAL: June 26 19 29

20 UNDERTAKER: Wm J Rickert Sons ADDRESS: Rockville

Filed ... 19 ...

Keep in a dry temperature. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 47167

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57

E 47167

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hospital (Ward) 10-13

2-FULL NAME Bertie Lieberman

(a) RESIDENCE No. 1419 E. Eager St. (Usual place of abode) ST., WARD

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? 26 yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Simon Lieberman

6 DATE OF BIRTH (month, day, and year) unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER S. Rubin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Esther

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Simon Lieberman (Address) 1419 E. Eager St.

15 Filed 6/26/1929 C. HAMPTON JONES, M. D. Registrar

Dat

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25, 1929

17

I HEREBY CERTIFY, That I attended deceased from June 14, 1929, to June 25, 1929

that I last saw her alive on June 25, 1929,

and that death occurred, on the date stated above, at 11 30 A. m.

The CAUSE OF DEATH* was as follows:

Diabetic Gangrene Lower Extremity

Affe operation - gangrene extended up the thigh.

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Myocardial failure

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 6-19-29

Was there an autopsy? No

What test confirmed diagnosis? Exam of Stump.

(Signed) Matthew Linde, M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rehrsen Hebrew Rm

DATE OF BURIAL 6/26 1929

20 UNDERTAKER Jack Levin's

ADDRESS 1459 E Balt St

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47168 E 47168

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hospital (WARD) 14-20

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Gorman Gorans

(a) RESIDENCE NO. 525 E. Winston Ave. WARD Harford Co.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Gertrude Gorans

6 DATE OF BIRTH (month, day, and year) 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) C&O

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Harford Co. Md

PARENTS

10 NAME OF FATHER Gorans

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Georgeanna Buckley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Gertrude Gorans

(Address) 525 Winston Ave

15 Filed JUL 26 1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-23 1929

17 I HEREBY CERTIFY, That I attended deceased from 6-9- , 1929, to 6-23- , 1929, that I last saw him alive on 6-23- , 1929, and that death occurred, on the date stated above, at 4:05 a m.

The CAUSE OF DEATH* was as follows:

Acute appendicitis
Rupture.

(duration) yrs. 1 mos 15 ds.

CONTRIBUTORY (Secondary) Appendiceal abscess

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 6/9/29

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) H. Baker M. D.

(Address) 600 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Union Chapel Cem DATE OF BURIAL June 26 29

20 UNDERTAKER Samuel Hemsley ADDRESS 518 N Gilmor

Spec.—1-10-21—M&T—1500 Bks.

225317

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 47169

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL (ST.) (WARD) 17-24

REGISTERED No. 159-001 E 47169

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Julia Cantos

(a) RESIDENCE No. 1147 Myrtle Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: black

5 (Single, Married, Widowed, or Divorced, write the word): Single

5a If married, widowed, or divorced (HUSBAND of (or) WIFE of):

6 DATE OF BIRTH (month, day, and year): 4/14/23

7 AGE — Years: 6 — Months: 2 — Days: 10 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: John Cantos

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Anna Dobson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

Date 6/24/1929 HAMILTON JONES, M. D.

Registrar

CN 261929

For [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 24 1929

17

I HEREBY CERTIFY, That I attended deceased from May 14, 1929. to June 24, 1929.

that I last saw h[illegible] alive on June , 19 .

and that death occurred, on the date stated above, at 7 [illegible] m.

The CAUSE OF DEATH* was as follows:

Hydrocephalus

Cyst (duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Pneumonia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of May 17, 1929

Was there an autopsy? yes

What test confirmed diagnosis? Operation,

(Signed) E. C. Goodwin M. D.

6/24/1929 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem DATE OF BURIAL June 26 1929

20 UNDERTAKER: Samuel Wemley & Bro ADDRESS 518 N Bdle

IMPORTANT. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47170

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47170

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1702 N Charles ST. 12-19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William H Biser

(a) RESIDENCE NO. 1702 N Charles ST., WARD Pittsburg Pa

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): ~~M~~ ~~Single~~

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 14 - 73

7 AGE: Years 55 | Months 9 | Days 11 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Contractor

(b) General nature of industry, business, or establishment in which employed (or employer) Engineer

(c) Name of employer 030

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER J. P Biser

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Lipon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Thomas M Lawson

(Address) 1702 N Charles

15 Filed JUN 26 1929 H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25, 29

17 I HEREBY CERTIFY, That I attended deceased from May 18, 1929, to June 25, 1929, that I last saw him alive on June 24, 1929 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Carcinomatosis

(duration) revered yrs. mos. ds.

CONTRIBUTORY (Secondary) Carcinoma of stomach

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) H W Wortley M. D.

6/26 1929 (Address) 2020 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Brunswick Md — DATE OF BURIAL: June 28 1929

20 UNDERTAKER: W M Routson — ADDRESS: 2238 N Mts

Spec.—1-10-21—M&T—1500 Blks.

E 47171

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47171

CERTIFICATE OF DEATH.

141

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Howard A. Kelly Hospital Inc. ST. 14 WARD 20

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa B Deschamps

(a) RESIDENCE NO. Sumter S. C. ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 1 mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) W[illegible]: H. C. Deschamps

6 DATE OF BIRTH (month, day, and year): March 9 1873

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
56	3	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Sumter South Carolina

PARENTS

10 NAME OF FATHER: B. J. Barnett

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Zelda Longea

13 BIRTHPLACE OF MOTHER (city or town) (State or country): New York S. C.

14 Informant (Address): H. C. Deschamps Sumter S. C.

15 [illegible]

UN 26 1929

C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 25 1929

17

I HEREBY CERTIFY, That I attended deceased from May 21, 1929, to June 25, 1929, that I last saw her alive on June 25, 1929, and that death occurred, on the date stated above, at 5:10 p. m.

The CAUSE OF DEATH* was as follows:

Infected endometritus

3 months (duration)

CONTRIBUTORY (Secondary) Peritonitis [illegible] mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? Yes Date of June 3/29

Was there an autopsy? No June 14/29

What test confirmed diagnosis? Microscopic examination

(Signed) Edmund Kelly M. D.

June 25, 1929 (Address) 1418 Eutaw Place, Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sumter S. C. DATE OF BURIAL June 26 29

20 UNDERTAKER: Chas. G. Black ADDRESS 142 W. Northam

TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47172

CERTIFICATE OF DEATH

90

E 47172

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1624 Latrobe St. 12-19 Ward)

2-FULL NAME Wesley C. Spriggs. (O)

(a) RESIDENCE NO. 1624 Latrobe St. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Married.

5a If married, ~~widowed~~ HUSBAND of ~~XXXXXXX~~ Viola Spriggs. (O)

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	81	----------		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Boston. Mass.

(State or country)

PARENTS

10 NAME OF FATHER John Wesley Spriggs. (C)

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Martha Newman. (O)

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Maryland.

14 Informant Otha T. Spriggs. (C) brother.

(Address) 2623 Boone St.

15 Filed (19) HAMILTON JONES, M. D. Registrar

N 261929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.
Acute dilatation of the Heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Reinhardt, M. D.

6/25, 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
National Cemetery	June 27 1929

20 UNDERTAKER Thomas E. Kelson ADDRESS 1903 Preastman

important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47173

100-001

E 47173

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Hopkins Hospital St., 10-14 Ward)

2-FULL NAME Dorothy C. Harvey

(a) RESIDENCE NO. 715 N. Gay St. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F	W	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Apr 5/29

7 AGE	Years	Months 2	Days 18	IF LESS than 1 day hrs. or min.
		3	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Renzig Harvey

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Grace Mayhew

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md.

14 Informant Edgar Dales
(Address) 715 N. Gay St.

15 Filed JUN 26 1929 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23 192 29

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (Primary)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. E. Brack, M. D.

6/26/29 (Address) 500 E. North Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery — DATE OF BURIAL 6/26 1929

20 UNDERTAKER William Cook — ADDRESS 217 St. Paul

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47174

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. E 47174

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH
CITY OF BALTIMORE: (No. Baltimore City Hospitals ST., 17-49 WARD)

2—FULL NAME Henry Joseph Johnson

(a) RESIDENCE NO. 428 Kerryman ST., WARD
(Usual place of abode)
Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if foreign birth? — yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	64			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer C/O

9 BIRTHPLACE (city or town)
(State or country) Maryland

PARENTS

10 NAME OF FATHER Daniel Johnson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Records of
(Address) Baltimore City Hospitals

15 Filed JUN 26 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 17, 1929, to June 24, 1929, that I last saw him alive on June 24, 1929, and that death occurred, on the date stated above, at 4:10 A. m.

The CAUSE OF DEATH* was as follows:
Chronic Myocarditis Terminal Pneumonia

CONTRIBUTORY (Secondary) Hypertension: Arteriosclerosis: (duration) yrs. 8 mos. ds.
Cardiac Stenosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home
Did an operation precede death? No Date of —
Was there an autopsy? No
What test confirmed diagnosis? Clinical Course
(Signed) [illegible] M. D.
6-27, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Laurel Cemetery — DATE OF BURIAL June 26, 1929

20 UNDERTAKER Wm. R. G. Elliott — ADDRESS 1725 Madison Ave.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47175

CERTIFICATE OF DEATH

198

E 47175

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St. 17-24 Ward)

2-FULL NAME John F Finger

(a) RESIDENCE NO. 704 Penna Ave. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Anna K. Finger

6 DATE OF BIRTH (month, day, and year) March 3-1857

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	72	3	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Grocer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Self

034

9 BIRTHPLACE (city or town)
(State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Anna K. Finger
(Address) 704 Penna Ave

15 Filed ..... 19 ..... JAMES KEVAN JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy (Coroner, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Incised wound of right axilla.
Homicide.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Hemorrhage

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? 704 Penna Ave

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) Eugene Zeller, M. D.

6/24 19 29 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem. — DATE OF BURIAL 6-26 1929

20 UNDERTAKER Mrs Chas A. Rohde — ADDRESS 2327 Edmondson Ave

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47176

CERTIFICATE OF DEATH

100-001 E 47176

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1948 W Mulberry ST. 20-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Nellie T. Graves

(a) RESIDENCE NO. 1948 W Mulberry ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 2nd 1908

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21	0	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Office Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Sumner D. Graves

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Sarah A Lamley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Sarah A. Lamley

(Address) 1948 W Mulberry St

15 Filed JUN 26 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-24-29

17 I HEREBY CERTIFY, That I attended deceased from July, 1928 to June 24, 1929 that I last saw h[illegible] alive on June 22, 1929 and that death occurred, on the date stated above, at 4 25 AM. The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Chr. bronchitis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Lab.

(Signed) Isidor J. Levy, M. D.

(Address) 1924 Eutaw place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem.	6-26 1929

20 UNDERTAKER Wm Chas A G Rohde ADDRESS 2327 Edmondson

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47177

CERTIFICATE OF DEATH

90

E 47177

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Baltimore City Hosp. ST. 18-26 WARD)

2—FULL NAME Herbert Johnson

(a) RESIDENCE NO. 247 Amity ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Nellie Johnson

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	36			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer.

(b) General nature of industry, business, or establishment in which employed (or employer) ...

(c) Name of employer ...

9 BIRTHPLACE (city or town) (State or country) Ga

PARENTS

10 NAME OF FATHER Henry Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Celenia Bashill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Hospital Record

(Address)

15 JUN 26 1929 19 ... Registrar. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/22/29

17 I HEREBY CERTIFY, That I attended deceased from 4/20, 1929, to 6/22, 1929

that I last saw him alive on 6/22, 1929

and that death occurred, on the date stated above, at 11 P a.m.

The CAUSE OF DEATH* was as follows:

Leuy abscess, left side

(duration) Unknown

CONTRIBUTORY (Secondary) Chronic myocarditis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. L. Tompkins, M. D.

(Address) Balto. City Hosp. 6/28 1929

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

JUN 26 1929

Spec.—2-29-28—L. F. S.—500 Blks.

E 47178

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

L-002

127 E 47178

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3829 Hudson ST., No. 37 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Schellenschlager

(a) RESIDENCE NO. 3829 Hudson ST., 26 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Lydia Schellenschlager

6 DATE OF BIRTH (month, day, and year) July 6th 1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	11	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER Matthias Schellenschlager

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Emma Mabel Mayer

(Address) 3829 Hudson St.

15 261929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 22/29

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1929, to June 23, 1929, that I last saw h alive on June 22, 1929, and that death occurred, on the date stated above, at 8.50 p. m.

The CAUSE OF DEATH* was as follows:

Chr. Myocarditis
Chr. Nephritis
Uraemia 2 Weeks.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Joseph Townley M. D.

19 (Address) 800 S. Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto. Cemetery — DATE OF BURIAL June 27 1929

20 UNDERTAKER Leo J. Frain Inc. — ADDRESS 400 N. Gay St.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47179 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ E 47179

CERTIFICATE OF DEATH

31

1—PLACE OF DEATH

REGISTERED NO. 7-4

CITY OF BALTIMORE: (No. 2030 E. Pratt ST., 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles W. Hopkins

(a) RESIDENCE NO. 2030 E. Pratt ST., 2 WARD
(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. 10 mos. 5 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A. Hopkins

6 DATE OF BIRTH (month, day, and year) Aug. 20th 1900

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
25	10	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Brass + Copper Co

(b) General nature of industry, business, or establishment in which employed (or employer) Roller Balto Tube Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Chas H. Hopkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Margt. Winkler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Mary A. Hopkins (Wife)

(Address) 2030 E. Pratt St.

15 Filed ....., 19.... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25/29

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1929, to June 25, 1929.

that I last saw h... alive on June 25, 1929

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Laryngeal Tuberculosis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas D Lawrence M. D.

6/26, 1929 (Address) 7811 Pulaski Hy

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park.	June 28 1929
20 UNDERTAKER Lilly + Gile Inc	ADDRESS 400 S. Mys

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47180

CERTIFICATE OF DEATH

62 ✓

E 47180

1—PLACE OF DEATH

CITY OF BALTIMORE, (No.) 2430 Lafayette ave ST., 8-16 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Betty Lee Lewis

(a) RESIDENCE NO. 2436 Lafayette Av ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Baby

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 20/29

7 AGE	Years	Months	Days 6.	If LESS than 1 day, hrs. or min.
	—	—	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Warren Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Grace Andrews

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Warren Lewis

(Address) 2430 Lafayette ave

15 Filed 6/26/29 16 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26, 1929

17

I HEREBY CERTIFY, That I attended deceased from June 20, 1929 to June 26, 1929.

that I last saw h alive on June 25, 1929

and that death occurred, on the date stated above, at 530 A m.

The CAUSE OF DEATH* was as follows:

Status Lymphaticus

CONTRIBUTORY (Secondary) Cardiac Dilatation (duration) yrs. mos. 6 ds. 1/2 hour.

18 Where was disease contracted (duration) yrs. mos. ds.

If not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Thyroid Extract

(Signed) Albert Cyriax M. D.

6/26 1929 (Address) 915 N Mt Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery — DATE OF BURIAL June 26 1929

20 UNDERTAKER Jno. C. Mullen & Son — ADDRESS 2334 E Baltimore St

Spec.—1-10-21—M&T—1500 Bks.

E 47181 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 47181

REGISTERED NO. 161

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) University Hospital (Ward) 23-31

2-FULL NAME Baby Girl Harris

(a) RESIDENCE NO. 33 W West St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6-20-29.

7 AGE — Years | Months | Days: 2 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER David Harris

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C

12 MAIDEN NAME OF MOTHER Lillian Howell

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant (Address)

15 Filed 6-29 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-22 1929

17 I HEREBY CERTIFY, That I attended deceased from 6-20 1929 to 6-22 1929, that I last saw her alive on 6-22 1929, and that death occurred, on the date stated above, at 8.—P m.

The CAUSE OF DEATH* was as follows:

Intra Cranial Hemorrhage

CONTRIBUTORY (Secondary) Trauma @ birth (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? (duration) yrs. mos. ds.

Did an operation precede death? (Date of)

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Lewis T. Longfield, M. D.

(Address) Mid. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

20 UNDERTAKER — ADDRESS

JUN 26 1929

...TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 47182

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47182

CERTIFICATE OF DEATH.

REGISTERED NO. 161-08

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital 11-15 ST., WARD)

2-FULL NAME Baby Boy Winters

(a) RESIDENCE NO. 24 E. Mt. Vernon Place ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 6-20-29

7 AGE — Years | Months | Days | If LESS than 1 day, 7 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Maryland.

PARENTS

10 NAME OF FATHER: Wilbur Winters

11 BIRTHPLACE OF FATHER (city or town) (State or country): W. Va.

12 MAIDEN NAME OF MOTHER: Katherine Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): W. Va

14 Informant (Address)

15 Filed JUN 26 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6-20 19 29

17 I HEREBY CERTIFY, That I attended deceased from 6-20 19 29, to 6-20 19 29 that I last saw h[illegible] alive on 6-20 19 29 and that death occurred, on the date stated above, at 11 20 P. m.

The CAUSE OF DEATH* was as follows:

Premature Infant

30 weeks

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Premature Separation of Placenta (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [signature] M. D.

(Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

JUN 26 1929

X TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47183

CERTIFICATE OF DEATH

E 47183

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST., 7 WARD)

REGISTERED NO. 12-31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Hanazawa

(a) RESIDENCE NO. 131 W. 20th st. ST., WARD Norfolk Va.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 mos. Unknown ds. How long in U. S., if foreign birth Unknown mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	~~Yellow~~ Jap.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie Hanazawa

6 DATE OF BIRTH (month, day, and year) 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Japan

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Japan

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records

(Address)

15 Filed 6-29 C. HAMPSON JONES, M. D. Registrar

Par

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 19, 1929, to June 25, 1929, that I last saw him alive on June 25, 1929 and that death occurred, on the date stated above, at 12.30 a. m.

The CAUSE OF DEATH* was as follows:

Empyema (mixed gas bacillus infection).

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical and autopsy

(Signed) Henry C. Arnold M. D.

6-25, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Norfolk Va.	June 29, 1929
20 UNDERTAKER Mrs. R. G. Elliott	ADDRESS 125 Ashland ave.

Spec.—1-12-23—M&T—500 Blks.

E 47184 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 47184

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1515 N. Rose ST. 8-16 WARD)

2-FULL NAME Mary M. Will

(a) RESIDENCE NO. 1515 N. Rose ST., WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? Life yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George Will

6 DATE OF BIRTH (month, day, and year): July 27 1869

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
59	10	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Anthony G Stump

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Margaret Base

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Belle Franke

(Address) 1515 N Rose St

Filed 6 26 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/25 1929

17 I HEREBY CERTIFY, That I attended deceased from May 30th 19 29, to June 25th 19 29, that I last saw h[illegible] alive on June 25th 19 29, and that death occurred, on the date stated above, at 5 37 m

The CAUSE OF DEATH* was as follows:

Insuff & Stenosis Mitral Valve

Cause of Disability

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. mos 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. E. Fortner M. D.

(Address) 1501 E. Eager

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL 6 27 1929

20 UNDERTAKER: Albert L Hiltz — ADDRESS 1606 N Chester St

Spec.—1-12-23—M&T—500 Blks.

E 47185

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161-60 ✓ E 47185

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1815 N. Montford Ave ST.) 8-16 (WARD)

REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary May Ermer

(a) RESIDENCE NO. 1815 N Montford Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None

6 DATE OF BIRTH (month, day, and year) 6/25/29

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	0	0	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Charles R. Ermer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Elizabeth M Lind

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Mrs Charles R Ermer

(Address) 1815 N Montford Ave

Filed 6-26-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1929

17 I HEREBY CERTIFY, That I attended deceased from June 25 1929, to June 26 1929, that I last saw her alive on June 24 1929, and that death occurred, on the date stated above, at 12.40 P m

The CAUSE OF DEATH* was as follows:

Prematur C Birth of Eight months

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? ngtr

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A. C. Heacock, M. D.

6/26 1929 (Address) 1907 Guilford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Balto Cemetery DATE OF BURIAL 6/27 1929

20 UNDERTAKER Albert L Waltz ADDRESS 1606 N Chester St

Cor.—12-9-25—A Co.—200 Bks.

E 47186

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 **E 47186**

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 329 Stinson St. 90-28 Ward)

2-FULL NAME Albert L. Younger

(a) RESIDENCE NO. 2039 Hollins St. ____ Ward ____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Divorced

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Nellie Reiter Younger

6 DATE OF BIRTH (month, day, and year) About 1859

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
About	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore County

(State or country) Maryland

PARENTS

10 NAME OF FATHER Lemuel Younger

11 BIRTHPLACE OF FATHER (city or town) Baltimore

(State or country) County Maryland

12 MAIDEN NAME OF MOTHER Anna Fisher

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore County Maryland

14 Informant Mrs. Thompson

(Address) 2039 Hollins Street

26 1929 ....., 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

(Signed) Chas. H. Brooke M. D.

(Coroner)

June 26 1929 (Address) 3601 Third St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery — Date of Burial June 29 1929

20 UNDERTAKER Ralph Cook — ADDRESS 1003 West Baltimore St

very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47187

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-006 E 47187

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 537 Tennyson St., WARD) 7-24

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Daniel White

(a) RESIDENCE NO. 537 Tennyson ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: col

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, ~~widowed, or divorced~~ HUSBAND of ~~(or) WIFE of~~: Mary White

6 DATE OF BIRTH (month, day, and year): 1879

7 AGE: Years 50 | Months — | Days | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): 0/H

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Washington D.C.

PARENTS

10 NAME OF FATHER: Jos. White

11 BIRTHPLACE OF FATHER (city or town) (State or country): Washington D.C.

12 MAIDEN NAME OF MOTHER: Mc Gowan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant: Mary White

(Address) 537 Tennyson St

15 Date received: 2 6 1929 G. HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 24 29

17 I HEREBY CERTIFY, That I attended deceased from June 18, 1929, to June 24, 1929, that I last saw him alive on June 24, 1929, and that death occurred, on the date stated above, at 8.55 P. m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin. Exam.

(Signed) Hank G. Hamm M. D.

19 (Address) 1016 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: 6-26 1929

20 UNDERTAKER: Daniel Easton

ADDRESS 9/H Ga Ave

Spec.—1-12-23—M&T—500 Bks.

E 47188

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47188

CERTIFICATE OF DEATH.

REGISTERED NO. 101

1-PLACE OF DEATH Provident Hospital

CITY OF BALTIMORE: (No. [redacted] ST., [redacted] WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lewis Mills Burkett

(a) RESIDENCE NO. 1021 Carlton ST., [redacted] WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Negro

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 7 1925

7 AGE: Years 3 yrs. Months 11 Days 16 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): Chicken

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant [redacted] (Address) [redacted]

15 6-26-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/24 1929

17 I HEREBY CERTIFY, That I attended deceased from 5-28 1929 to 6-24 1929, that I last saw him alive on 6-24 1929, and that death occurred, on the date stated above, at 1.40 a.m.

The CAUSE OF DEATH* was as follows:

Primary - Umbilical Hernia

Secondary - Intussusception

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) C. F. Hancock M. D.

6/25 1929 (Address) [redacted]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem. DATE OF BURIAL 6-26 1929

20 UNDERTAKER Leonard Easton ADDRESS [redacted]

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47189

CERTIFICATE OF DEATH.

72-001

E 47189

1-PLACE OF DEATH

City of BALTIMORE: (No.) 44-51 Annabel St. (Ward) 25-32

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Victor S. Corbi

(a) RESIDENCE NO. 2451 Annapolis Rd St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Francis H Corbi

6 DATE OF BIRTH (month, day, and year): May 15 1866

7 AGE: Years 63; Months 3 mo; Days 11; IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Confectionery

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Italy

(State or country)

10 NAME OF FATHER: Anthony Corbi

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Italy

12 MAIDEN NAME OF MOTHER: Marie Protesta

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Italy

PARENTS

14 Informant: Mrs Eugene Kelly

(Address) 2451 Annapolis ave

261929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 26. 1929

17 I HEREBY CERTIFY, That I attended deceased from May 2, 1929, to June 26, 1929, that I last saw h— alive on June 25, 1929, and that death occurred, on the date stated above, at 9:10 a.m.

The CAUSE OF DEATH* was as follows: Carcinoma of Liver

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. Hampson Jones, M. D.

6-26-29 (Address) 5 E Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery Date of Burial June 28. 1929

20 UNDERTAKER: Bernard A Funk ADDRESS 734 Poplar Grove St

very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47190 — 31 — E 47190

1—PLACE OF DEATH — REGISTERED NO.

CITY OF BALTIMORE: (No.) 5925 Bellona Ave (WARD) 27-48

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William H. Harrison

(a) RESIDENCE NO. 5925 Bellona ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of: Ella [illegible]

6 DATE OF BIRTH (month, day, and year): Sept 25 1883

7 AGE — Years: 45 — Months: 9 — Days: — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Electrician

(b) General nature of industry, business, or establishment in which employed (or employer): Retired.

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Albert W Harrison

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md

12 MAIDEN NAME OF MOTHER: Elizabeth McNier

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Albert W. Harrison
(Address): 5925 Bellona Ave

15 Filed 6/27, 1929 — HAMILTON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 25-1929

17 I HEREBY CERTIFY, That I attended deceased from June 18, 1929, to June 25, 1929, that I last saw him alive on June 24, 1929, and that death occurred, on the date stated above, at 3.00 p.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Sputum

(Signed) Geo U. Obocking, M. D.

6/26, 1929 (Address) 5830 York Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery

DATE OF BURIAL: 6/28 1929

20 UNDERTAKER: Wm Cook

ADDRESS: 121 St Paul St

Spec.-7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47191

CERTIFICATE OF DEATH

23

E 47191

1-PLACE OF DEATH Mercy Hospital. REGISTERED NO.

City of BALTIMORE: (No. 13-54 St. Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anthony Marcellea Marciglia

(a) RESIDENCE NO. 2601 Remington Rd St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 4½ yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 Color or Race White

5 Single, Married, Widowed, or Divorced (write the word) Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie

6 DATE OF BIRTH (month, day and year) June 28-1876

7 AGE Years 52 Months 11 Days 28 IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fruit Dealer

(b) General natore of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Italy

PARENTS

10 NAME OF FATHER Andrew Marciglia

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Italy

12 MAIDEN NAME OF MOTHER Lauterero

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Italy

14 Informant Minnie Marciglia

(Address) 2601 Remington Road

15 Filed JUN 27 1929 C. HAMILTON JONES M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

6-26-'29

17 I HEREBY CERTIFY, That I attended deceased from 6-24, 19 29, to 6-26 19 29

that I last saw him alive on 6-26, 19 29

and that death occurred, on the date stated above, at 4 25 m.

The CAUSE OF DEATH* was as follows:

Encephalitis

(duration) ..... yrs. ..... mos. 7+ ds.

CONTRIBUTORY (Secondary)

Pulmonary edema

(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted ?

If not at place of death? !

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J Leyko, M. D.

6/26. 19 29 (Address) Mercy Hosp # 2755

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

Date of Burial 6/29 19

20 UNDERTAKER Will Cook

ADDRESS 131 Fox Paul

Very important. See instructions on back of certificates. Be sure to print name, so that it may be properly classified. Exact statement of OCCUPATION is

Spec.—2-29-28—L. F. S.—500 Blks.

E 47192

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

107-001

1—PLACE OF DEATH

REGISTERED NO. E 47192

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Md Gen Hospital 17-50 WARD)

2—FULL NAME Wm H Norman

(a) RESIDENCE NO. 2509 N Charles St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX M

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of May A. Norman

6 DATE OF BIRTH (month, day, and year) Jan 1 1860

7 AGE Years 69 Months 5 Days 25 If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Wash Co. Md.

PARENTS

10 NAME OF FATHER Wm J Norman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Hinds

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant (Address) Hospital Record

15 Filed JUN 27 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/26/29

17 I HEREBY CERTIFY, That I attended deceased from 6/22/29, 19..., to 6/26/29, 19..., that I last saw ... alive on 6/26/29, 19..., and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows: Lobar Pneumonia

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Influenza

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of ...

Was there an autopsy? No What test confirmed diagnosis? Clinical.

(Signed) Jno W Hampson, M. D.

19 (Address) Md Gen Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

20 PLACE OF BURIAL, CREMATION OR REMOVAL Manassas Va

DATE OF BURIAL 6/28 1929

21 UNDERTAKER Wm Cook 6

ADDRESS 121 St Paul

Spec.—2-29-28—L. F. S.—500 Bks.

E 47193

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

+ 129 ✓

E 47193

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1142 Montpelier ST. 9-46 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Ann Windle

(a) RESIDENCE NO. 1142 Montpelier ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. 4 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, or Divorced, (write the word)
Female	white	widowed

~~If married, widowed, or divorced~~ ~~HUSBAND~~ of (or) WIFE of William H Windle

6 DATE OF BIRTH (month, day, and year) Sept 9, 1842

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	86	9	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Guernsey, England

PARENTS

10 NAME OF FATHER Abram Carre

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Mary LeMarie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Mrs Leah L Brack

(Address) 1142 Montpelier Street

15 [illegible] 27 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 10 — 1929 to June 24 1929

that I last saw h~~er~~ alive on June 24 1929

and that death occurred, on the date stated above, at 4.16 p.m.

The CAUSE OF DEATH* was as follows:

Nephritis and General debility

(duration) ~~1~~ yrs. ~~1~~ mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) ~~1~~ yrs. ~~1~~ mos. 4 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H Slaymaker, M. D.

June 25, 1929 (Address) 1900 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	June 27, 1929
20 UNDERTAKER Robt F Sumerlin	ADDRESS 1722 N Broadway

Spec.—1-10-21—M&T—1500 Bks.

2E 47194

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

REGISTERED NO. E 47194

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Beatrice Hay

(a) RESIDENCE NO. Severn - Md ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	5		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER George Hay

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Potts

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Reeds

(Address) JOHNS HOPKINS HOSPITAL

15 27 1929 H. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 1929

17 I HEREBY CERTIFY, That I attended deceased from June 18, 1929, to June 25, 1929, that I last saw her alive on June 25, 1929, and that death occurred, on the date stated above, at 9 35 P M.

The CAUSE OF DEATH* was as follows:

Heart failure

(Rupture Mycotic Aneurysm found at autopsy)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pyarthrosis - right knee

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home - Severn, Md.

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) S. A. Gladstone M. D.

, 19 (Address) J. H. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Harman. cemetery m.d. a. co. DATE OF BURIAL June 27, 29

20 UNDERTAKER Edward Bryan ADDRESS 1631 Orleans St

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47195 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 47195

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3228 Belair Road ST., 8- WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME ROSETTA M. CUNINGHAM

(a) RESIDENCE NO. 3228 Belair Road ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of James M. Cuningham

6 DATE OF BIRTH (month, day, and year) March 30, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	2	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER William Turner

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Not Known

14 Informant Mrs. James Ambrose (Grand-daughter)
(Address) 3228 Belair Road

15 27 1929 C. HAMILTON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24, 1929

17 I HEREBY CERTIFY, That I attended deceased from 5-31-, 1929, to 6-24, 1929

that I last saw her alive on 6-21-, 1929

and that death occurred, on the date stated above, at 8.10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic arteriosclerosis
Hypertension -
Chronic myocarditis -
Chronic nephritis (duration) yrs. mos. 25 ds.

CONTRIBUTORY (Secondary) cardiac decompensation.
(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? None

(Signed) George A Sanders, M. D.

6/26. 1929 (Address) 1517 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: June 27, 1929

20 UNDERTAKER: Henry Sander & Sons, Inc.

ADDRESS: BALTIMORE ST. & BROADWAY

Cor.—12-9-25—A Co.—200 Bks.

E 47196

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

89

E 47196

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) Pratt & Paca St. 8-45 Ward (If death occurred in a hospital or Institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Paul R. Buckal

(a) RESIDENCE NO. 3018 Clifton Park Terrace Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 55 yrs. 2 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary C. Buckal

6 DATE OF BIRTH (month, day, and year) April 3, 1874

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	55	2	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) Henry Bonnebon

(c) Name of employer Balto.

9 BIRTHPLACE (city or town) Md.

(State or country)

PARENTS

10 NAME OF FATHER Robert Buckal

11 BIRTHPLACE OF FATHER (city or town) Balto.

(State or country) Md.

12 MAIDEN NAME OF MOTHER Louise Mahn

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Mr. Robert J. Buckal

(Address) 3018 Clifton Park Terrace

15 Filed ....., 19.... C. HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquery (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquery (Coroner, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Angina Pectoris

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... mos. ..... ds.

(Signed) Edgar Tillard (Coroner) M. D.

6/26, 1929 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem. Date of Burial June 28, 1929

20 UNDERTAKER. Wm. Fickus Sons ADDRESS North & Pa

very important. See instructions on back of certificate.

Spec.—1-10-21—MAT—1500 Bks.

47197 2666 570

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 VE 47197

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., WARD)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Edward L. Harp. 3rd. 9-44

(a) RESIDENCE No. 1611 E. 30th ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. 11 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male
4 COLOR OR RACE: white
5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: ✓

6 DATE OF BIRTH (month, day, and year): 7-15-26

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
2	11	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: child

(b) General nature of industry, business, or establishment in which employed (or employer): ✓

(c) Name of employer: ✓

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Edward L. Harp Jr.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Md.

12 MAIDEN NAME OF MOTHER: Helen Seippel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md.

14 Informant: Records.
(Address) JOHNS HOPKINS HOSPITAL

15 Filed 271929 G. HAMPTON MORRIS, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6-26 1929

17 I HEREBY CERTIFY, That I attended deceased from 6-23 .19 29. to 6-26 .19 29.
that I last saw him alive on 6-26 .19 29.
and that death occurred, on the date stated above, at 10 a. m.
The CAUSE OF DEATH* was as follows:
Brain tumor, malignant

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Removal June 25, 1929
Was there an autopsy? Yes
What test confirmed diagnosis?

(Signed) I. Ridgway Tom M.D.
(Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Dorraine Cem DATE OF BURIAL June 28 1929

UNDERTAKER: Wm J. Tuckner ADDRESS Hons N.Y. Pa

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

45 ✓

E 47198

1—PLACE OF DEATH

REGISTERED NO. E 47198

CITY OF BALTIMORE: (No.) 2745 Tivoly ST., 9-46 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles J. Isagerson

(a) RESIDENCE NO. 2745 Tivoly Ln ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary A Isagerson

6 DATE OF BIRTH (month, day, and year) Dec 6 1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	6	19.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) Maryland Biscuit Co

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER George Isagerson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Catherine Summers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mary A Isagerson

(Address) 2745 Tivoly Ln

15 Filed 6-27-1929 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 1929

17 I HEREBY CERTIFY, That I attended deceased from April, 1928, to June 25, 1929, that I last saw him alive on June 25, 1929 and that death occurred, on the date stated above, at 6:35 P.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Sigmoid Colon.

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of May 1928

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Fritz J Kinzer M. D.

6/26/29 (Address) 2700 Hoffman St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemy.	June 27 1929.
20 UNDERTAKER	ADDRESS
Geo. J. Ruth	1725 Harford Av

Spec. E-1-10-27-M-C-500Bks.

E 47199

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47199

161-002

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bon Secours Hospital St., 20-26 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Genevieve Baby Girl Reuling

(a) RESIDENCE No. 1927 W. Baltimore St. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced. (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 6-26-29

7 AGE Years Months Days If LESS than 1 day, 7 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Elmer J Reuling

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Genevieve Schuyford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Elmer J Reuling

(Address) 1927 W Baltimore St

15 Filed 2/7/1929 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/26 1929

17 I HEREBY CERTIFY, That I attended deceased from 6/26, 1929 to 6/26, 1929.

that I last saw h alive on 6/26, 1929.

and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Asphyxia neonatorum

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage (?)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Thos. C. Stacy Jr M. D.

19 (Address) Bon Secours Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem DATE OF BURIAL 6/27/29

20 UNDERTAKER George A Staley Inc ADDRESS Baltimore

TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47200

1-PLACE OF DEATH

X 29-491 E 47200

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of Baltimore: (No. Johns Hopkins Hospital St., 7-9 Ward)

2-FULL NAME Wm. Leroy Himmelheber

(a) RESIDENCE NO. Eastern & Mace Aves Balto. Co. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of (Dec 2/1915)

6 DATE OF BIRTH (month, day, and year) Dec 2/1915

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	13	0	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer) Public School
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto. Co., Md

PARENTS

10 NAME OF FATHER Fred Himmelheber

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto. City. Md.

12 MAIDEN NAME OF MOTHER Catherine Kramer

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto City

14 Informant Mother
(Address) Eastern & Mace Aves

15 Filed 19 HAMILTON JONES, M. D.
271529 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 23/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tetanus- Hand injured by exploding fire cracker one week before.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. E. Pacca, M. D.

6-25-29 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak. Lawn

DATE OF BURIAL 6/27 1929

20 UNDERTAKER John G. Connelly

ADDRESS Essex, Md

important. See instructions on back of certificate.

Spec.—2-20-28—L. F. S.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47201

CERTIFICATE OF DEATH

E 47201

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2121 E. Federal St. ST., 8-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Rau

(a) RESIDENCE NO. 2121 E. Federal St. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Annie M. Rau (nee Kramer)

6 DATE OF BIRTH (month, day, and year) Oct. 10, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	8	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watch Maker

(b) General nature of industry, business, or establishment in which employed (or employer) 054

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore,
(State or country) Maryland

PARENTS

10 NAME OF FATHER George Rau

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Schaf

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs. Annie M. Rau.
(Address) 2121 E. Federal St.

15 Filed 19 C. HAMILTON JONES, M. D.
Registrar

7 1929 By Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24-29

17 I HEREBY CERTIFY, That I attended deceased from June 15, 1929, to June 27, 1929, that I last saw h in alive on June 27, 1929 and that death occurred, on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Chr. Osteosclerosis
Angina Pectoris

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) M. D.

6/26/29 (Address) 156 N. Milton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: June 27 19 29

20 UNDERTAKER: Harry A. Wiese, 531 N. Lombard St. — ADDRESS

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47202

CERTIFICATE OF DEATH.

44

E 47202

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West Balto Genl Hosp ST. 2069 WARD)

2-FULL NAME Mrs. Nellie Bosley.

(a) RESIDENCE NO. 2651 Frederick Ave ST., WARD D.
(Usual place of abode)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm. J. Bosley.

6 DATE OF BIRTH (month, day, and year): Sept. 20, 1890

7 AGE — Years: ~~39~~ 38 — Months: 9 — Days: 5 — If LESS than 1 day, hrs or min:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housf. 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Wm. Bosley.

11 BIRTHPLACE OF FATHER (city or town) (State or country): ~~Ireland~~ Balto.

12 MAIDEN NAME OF MOTHER: Ellie Maden

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Hospital Records
(Address)

15 Filed 6/26/29 C. HARRISON JONES, M. D. Registrar

N 271525

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/25/29 19

17 I HEREBY CERTIFY, That I attended deceased from 6/18/29, 19, to 6/25/29, 19, that I last saw her alive on 6/25/29, 19, and that death occurred, on the date stated above, at 5 30 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary): Chr. Myocarditis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jack J. Singer, M. D.

6/25/29, 19 (Address) West Balto Genl Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cem. DATE OF BURIAL: June 28 1929

20 UNDERTAKER: Harry A. Wiska ADDRESS: 531 W. Lombard St.

Spec.—2-29-48—B. F. S.—500 Bks.

Permit for burial to undertaker Lady & Undertaking Co. (3rd) (6-27-29)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47203

CERTIFICATE OF DEATH

E 47203

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST., 4-7 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Pritchett

(a) RESIDENCE NO. Centreville, Maryland ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1916

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	13			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Mercy Hospital

(Address) Records

15 Filed 6-27-1929, HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/27/29

17 I HEREBY CERTIFY, That I attended deceased from 6/26/29, 19..., to 6/27/29, 19...,

that I last saw h.i.M alive on 6/27/29 19

and that death occurred, on the date stated above, at 8 25 A.M. m.

The CAUSE OF DEATH* was as follows:

Scarlet fever.

?

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Subacute bacterial Endocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home -

Did an operation precede death? No Date of

Was there an autopsy? Yes -

What test confirmed diagnosis?

(Signed) Melson Carey, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Centreville Md	June 25 1929

20 UNDERTAKER	ADDRESS
John C. Miller & Sons	

Cor.—10-10-29—A Co.—100 Bks.

E 47204 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1917 E 47204

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Provident Hosp. St., 12-30 (Ward)

2-FULL NAME Craig Hayes - Craige Hayes.

(a) RESIDENCE NO. 524 W. Barre St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write this word)
Male	Col	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year)

7 AGE Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
about 32			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Unknown
(b) General naturo of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Police Record
(Address) N. W. Cor

15 Filed C. HAMPSON JONES, M. D.
N 27929 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 14th 1924

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest + Autopsy (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

(Homicide)

Hemorrhage due to Pistol wound of Abdomen (duration) ... yrs. Unknown

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? In front 554 Canal

Did an operation precede death? Yes Date of June 14

Was there an autopsy? Yes

What test confirmed diagnosis? Regular Routine

(Signed) ... M. D.

June 15 1924 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: PUBLIC CEMETERY — DATE OF BURIAL: JUN 2 7 1924

20 UNDERTAKER: Commissioner Health — ADDRESS

important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 47205

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

182

E 47205
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Found floating in the water at
City of Baltimore: (No. Pier No.4 Pratt St. St. 4-6 Ward)

2-FULL NAME Unknown.

(a) RESIDENCE NO. Do not know. St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Do not know.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	70	----------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Do not know.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Do not know.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Police Report. C.D.
(Address)

15 Filed ..... 19 HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Body found June 15, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning.
Probably accidental.

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Fennard, M. D.

6/26. 1929 (Address) 107 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY

DATE OF BURIAL 19

20 UNDERTAKER Commissioner Health

ADDRESS

JUN 27 1929

Per

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47206

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47206

CERTIFICATE OF DEATH

90

REGISTERED NO. 76-2

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3220 Eastern Ave ST.) WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph Simonik

(a) RESIDENCE NO. 3220 Eastern Ave ST., 26 WARD
(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 11 mos. 0 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Martha Simonik

6 DATE OF BIRTH (month, day, and year) Sept. 19th 1886

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
42	9	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker

(b) General nature of industry, business, or establishment in which employed (or employer) 853

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Moravia

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Moravia

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Moravia

14 Informant Martha Simonik

(Address) 3220 Eastern ave

File JUN 27 1929 C. HAMPSON JONES, M. D.

Date June 27th 1929 Undertaker

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27th 29

17 I HEREBY CERTIFY, That I attended deceased from June 6— 1929, to June 27— 1929

that I last saw h[illegible] alive on June 26— 1929

and that death occurred, on the date stated above, at 6.30 1 m.

The CAUSE OF DEATH* was as follows:

Valvular Cardiac Dis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Anasarca + Cardiac Failure

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) Chas C Brooke

, 19 (Address) 125 E Broadway M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Edgewood Cemetery

DATE OF BURIAL June 29 1929

20 UNDERTAKER Lilly + Sons Inc

ADDRESS 403 N. Mon St

Cor.—12-9-25—A Co.—200 Bks.

E 47207

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 47207

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Md. General Hospital St. 11-24 Ward)

2-FULL NAME Robert L. Barnum

(a) RESIDENCE NO. 54 Township Rd. Dundalk Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 6 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella V. Barnum

6 DATE OF BIRTH (month, day, and year) Jan. 17, 1902

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	27	5	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Blower at

(b) General nature of indnstry, business, or establishment in which employed (or employer) Blast Furnace

(c) Name of employer Bethlehem Steel Co.

9 BIRTHPLACE (city or town)

(State or country) Scottsdale, Pa.

PARENTS

10 NAME OF FATHER Edgar L. Barnum

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Scottsdale, Pa.

12 MAIDEN NAME OF MOTHER Carrie Dumnire

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Scottsdale, Pa.

14 Informant Ella V. Barnum

(Address) 54 Township Rd. Dundalk

15 Filed C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 29

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

3rd Burns on Abdomen. Chest & Face & back.

(Duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Accident fell on Hot Molten Metal

(duration) yrs. ds.

(Signed) H. Leuth M. D.

(Coroner)

, 19 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. 6 ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Sparrows Point

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkersburg W. Va. Date of Burial June 27 1929

20 UNDERTAKER John J. McEnny ADDRESS 715 Light St

271929

very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 47208

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47208

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No.) 414 Calvin Ave (Ward) 12-50

2-FULL NAME Olivia M Childs

(a) RESIDENCE NO. 414 Calvin ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred ~~1~~ yrs. mos. ds. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Emory M. Childs

6 DATE OF BIRTH (month, day, and year) May 1—1865

7 AGE — Years: 64 — Months: 1 — Days: 25 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: at Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Balto Co.

PARENTS

10 NAME OF FATHER Turner

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Balto Co.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Balto Co

14 Informant Mr. Emory M. Childs

(Address) 414 Calvin ave

15 C. HAMPSON JONES, M. D.

Dat[illegible] 1929 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 9/26 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ~~his~~ death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. Harold Monroe M. D.

(Coroner)

9/27, 1929 (Address) 9632 Reisterstown Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oakley Cemetery Balto Co Date of Burial June 25 1929

20 UNDERTAKER A S Marshall ADDRESS 3539 Gill Road

271929

very important. See instructions on back of certificate. FAILURE STATEMENT OF OCCUPATION IS

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47209

1-PLACE OF DEATH

City of Baltimore: (No. John Hopkins Hosp St., 7-11 Ward)

2-FULL NAME Emil G Tibull

(a) RESIDENCE NO. 2924 Mc Elderry St., Ward
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

188-103

E 47209

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) ~~WIFE~~ of Bessie O. Tibull

6 DATE OF BIRTH (month, day, and year) March 23/65

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	64			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Iron worker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer 079

9 BIRTHPLACE (city or town)
(State or country) Baltimore

PARENTS

10 NAME OF FATHER Frederick Tibull

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany.

12 MAIDEN NAME OF MOTHER Caroline Meike

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs Bessie O Tibull
(Address) 2924 Mc Elderry St

15 Filed 19 C. HAMPSON JONES, M. D. Registrar
Per RPH

271699

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-24 192 29

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest
(Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Extra Dural Hemorrhage due to Fract. Fract. base Skull } an accident
Injury struck by automobile on 6/22/29
Mommouth & Caroline
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Fracture R. Fibia & Fibula & R Humerus
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Mommouth & Caroline

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) D J Fraunfelter, M. D.
6/29 19 29 (Address) 2939 Mc Elderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park & Cem.	June 27 19 29
20 UNDERTAKER	ADDRESS
Chas. H. Brown & Son.	901 Hollins St

important. See instructions on back of certificate.

Spec.—2-23-28—L. F. S.—500 Bks.

E 47210

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

43 E 47210

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 607 N. Charles St.) (WARD) 41-7

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Dr. Eberle Geddings Welch

(a) RESIDENCE NO. 607 N. Charles ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? 80 yrs. 3 mos. 26 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced
If HUSBAND of
(or) WIFE of Bertha C. Welch

6 DATE OF BIRTH (month, day, and year) Mar-1-1849

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	80	3	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Physician

(b) General nature of industry, business, or establishment in which employed (or employer) Medicine 54

(c) Name of employer Self

9 BIRTHPLACE (city or town) Anne Arundel Co.
(State or country) Maryland

PARENTS

10 NAME OF FATHER Dr. A. G. Welch

11 BIRTHPLACE OF FATHER (city or town) Anne Arundel Co.
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Emily Bedford

13 BIRTHPLACE OF MOTHER (city or town) Anne Arundel
(State or country) Maryland

14 Informant Mrs. Bertha C. Welch (wife)

(Address) 607 N. Charles St.

15 27 1928 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-26-29

17 I HEREBY CERTIFY, That I attended deceased from 1-26-29, 19 29, to 6-26, 19 29, that I last saw h[illegible] alive on 6-26, 19 29 and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

General debility
following several operations
for cancer of lip.

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac arteriosclerosis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of last Dec 29

Was there an autopsy? no

What test confirmed diagnosis? clinical.

(Signed) E. Dennis M. D.

6-26, 1929 (Address) Medical Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL June-28-29

UNDERTAKER Stewart Home Company

ADDRESS Balto.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47211

CERTIFICATE OF DEATH

E 47211

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat ST. 25-13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sarah M. Elizabeth Woods.

(a) RESIDENCE NO. Emmitsburg Md ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred \ yrs. \ mos. 21 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Dec 5 - 1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	6	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Religious. 065

(b) General nature of industry, business, or establishment in which employed (or employer): Same

(c) Name of employer: None

9 BIRTHPLACE (city or town) (State or country): New York.

PARENTS

10 NAME OF FATHER: Jones Woods

11 BIRTHPLACE OF FATHER (city or town) (State or country): Monaghan Ireland

12 MAIDEN NAME OF MOTHER: Catherine Keenan

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Emonghan Ireland

14 Informant: Mt Hope Friends (Address): Mt Hope Retreat

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

71929 Pat

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 26 1929

17 I HEREBY CERTIFY, That I attended deceased from June 5, 1929, to June 26, 1929, that I last saw h e alive on June 23, 1929 and that death occurred, on the date stated above, at 11.40 P. m.

The CAUSE OF DEATH* was as follows: Pulmonary Tuberculosis.

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Pneumonic Phthisis (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical & Microscopic

(Signed) Miller P. Hill M. D.

19 (Address) Mt Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Emmitsburg - Md — DATE OF BURIAL: June 29 1929

20 UNDERTAKER: Stewart & Horner Co. — ADDRESS: 108 W. North

Spec.–7-17-26—A Co.—200 Bks.

E 47212

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47212

CERTIFICATE OF DEATH

1-PLACE OF DEATH Jenkins Memorial Hospital — REGISTERED NO. ____

City of BALTIMORE: (No. 1000 Caton Ave St. 11-25 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Marie B. McFee

(a) RESIDENCE NO. 212 West Monument St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. — mos. — ds. How long in U. S. if of foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 ~~Single~~, Married, Widowed, ~~or Divorced~~. (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John R. McFee

6 DATE OF BIRTH (month, day, and year):

7 AGE — Years: About 65 — Months: — — Days: — IF LESS than 1 day ___ hrs. or ___ min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town):

(State or country) Maryland

PARENTS

10 NAME OF FATHER Not obtainable

11 BIRTHPLACE OF FATHER (City or town) "

(State or country) "

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town) "

(State or country) "

14 Informant "Hospital Record"

(Address)

15 Filed ____ 19 ____ C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1929

17 I HEREBY CERTIFY, That I attended deceased from April 8, 1929, to June 26, 1929, that I last saw h[illegible] alive on June 26, 1929, and that death occurred, on the date stated above, at 7:00 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast left.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) General Carcinomatosis

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Yes Date of May 1928

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Pathological

(Signed) Angelo L. Bonello, M. D.

, 19 (Address) St. Agnes Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Green Mount Cemetery — Date of Burial 6/28 1929

20 UNDERTAKER: Henry H. Mears and Son — ADDRESS 705 N. Calvert

271929

Be sure to write in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47213

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

45 E 47213

1—PLACE OF DEATH

REGISTERED NO. 2753

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 711 Gladstone ave ST. 27 WARD)

2—FULL NAME Mr Frank R. Burgess

(a) RESIDENCE NO. 711 Gladstone ST., 27 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. 11 mos. 24 ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 2, 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54	11	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Late N. P. Burgess

11 BIRTHPLACE OF FATHER (city or town) (State or country): Penna.

12 MAIDEN NAME OF MOTHER: Elizabeth Richardson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Jas G Burgess

(Address) 711 Gladstone

15 June 27, 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 26. 1929

17 I HEREBY CERTIFY, That I attended deceased from May 18, 1929, to June 26, 1929, that I last saw h— alive on June 26, 1929, and that death occurred, on the date stated above, at 4 P. m.

The CAUSE OF DEATH* was as follows:

Cancerous of Intestine

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Anaemia

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) John H Crain, M. D.

June 26 1929 (Address) 612 W 40 St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Green Mount Cemetery	6/28 1929
20 UNDERTAKER: Henry U. Mears and Son	ADDRESS: 605 N. Calvert

Spec.—1-10-21—M&T—1500 Bks.

E 47214 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 6 E 47214

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. 2-4 WARD)

2-FULL NAME Louis Howat

(a) RESIDENCE No. 236 S Castle St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1/12/29

7 AGE: Years | Months: 5 | Days: 15 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: John

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Carrie Pisior

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Records JOHNS HOPKINS HOSPITAL

15 Filed 27 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27 1929

17 I HEREBY CERTIFY, That I attended deceased from June 10. 1929. to June 27. 1929. that I last saw h alive on June 27. 1929, and that death occurred, on the date stated above, at 5 45 A m.

The CAUSE OF DEATH* was as follows:

Status Lymphaticus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) V. C. Goodwin M. D.

6/27. 1929 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Stanislaus DATE OF BURIAL: June 29 1929

20 UNDERTAKER: John M Weber ADDRESS: 451 N Chester St

TIONS is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47215

CERTIFICATE OF DEATH.

E 47215

1-PLACE OF DEATH

City of BALTIMORE: (No. Stone on Memorial Hospital St. 2 Ward)

REGISTERED NO. 188-001

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles L. Christie

(a) RESIDENCE NO. 3907 Hardberne ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Leonore D.

6 DATE OF BIRTH (month, day, and year): Dec 1899

7 AGE: Years 29 Months 6 Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Fr. Brakeman

(b) General nature of industry, business, or establishment in which employed (or employer): B. & O. R. Road

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Md

PARENTS

10 NAME OF FATHER: James Christie

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Md

12 MAIDEN NAME OF MOTHER: Susan Kress

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Penn

14 Informant: Mrs L. M. Christie

(Address): 3907 Hardberne ave

15 Filed: C. HAMILTON JONES, M. D. Registrar

2 71929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-26 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Crush & Fracture of Body
Caught between Cars.
B. & O. R. R (Accidental

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) Chas Morrissey M. D.
(Coroner)

6/27 1929 (Address) 3602 Roland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cem Date of Burial: 6/29/1929

20 UNDERTAKER: Harry A Witzke ADDRESS: 1537 Lombard St

very important. See instructions on back of certificate. CAUSE, Statement of OCCUPATION is

Spec.—2-29-28—L. F. S.—500 Bks.

E 47216

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47216

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 321 Scott ST. (WARD) 21-29

REGISTERED NO. 74-00

2—FULL NAME John Joseph Meisel

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(a) RESIDENCE NO. 321 Scott St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henrietta

6 DATE OF BIRTH (month, day, and year): Oct 1-59

7 AGE: Years 69; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Packer

(b) General nature of industry, business, or establishment in which employed (or employer): Baker Peterson

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: George H Meisel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Louisa Finke

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Wash. D C

14 Informant: Casper J Meisel

(Address) Wash D C

15 Filed ..., 19 ... HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 27-29

17 I HEREBY CERTIFY, That I attended deceased from 6/25, 1929, to 6/27, 1929, that I last saw him alive on 6/27, 1929, and that death occurred, on the date stated above, at 2.40 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

CONTRIBUTORY (Secondary) Cerebral arterio-sclerosis (duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. W. Guyton, M. D.

19 (Address) 237 Md. Ave, Balto, Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: 6/29 1929

20 UNDERTAKER: Wm Cook — ADDRESS: 1217 St Paul

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47217

CERTIFICATE OF DEATH.

90 E 47217

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) Union Memorial Hosp. St. (or Co.) Ward 50

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Florence Seerce

(a) RESIDENCE NO. 227 East 25th St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 Color or Race White

5 Single, Married, Widowed, or Divorced. (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Herbert

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE Years 60 Months Days IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER James Martinek

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Don't know

12 MAIDEN NAME OF MOTHER Mackey

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Don't Know

14 Informant James Martinek

(Address) Barclay - 31st Ave

15 Filed ..... 29 C. HARRISON JONES, M.D. Registrar

Per Asst

271929

very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 1929

17 I HEREBY CERTIFY That I took charge of the remains described above, held an Inquest (autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry, find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) Dan Morrissey (Coroner) M. D.

6/27, 1929 (Address) 3632 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death? .....

Former or usual residence .....

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Date of Burial 6/28 1929

20 UNDERTAKER William Cook ADDRESS 1217 St Paul

Spec.—1-10-21—M&T 1500 Blks.

E 47218

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 47218

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1733 Carswell St. (ST.) 9-46 (WARD)

2-FULL NAME Gertrude Silk

(a) RESIDENCE No. 1733 Carswell St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Daniel Silk

6 DATE OF BIRTH (month, day, and year) Oct 27-1873

7 AGE

Years	Months	Days
55	7	29

If LESS than 1 day, ... hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 000

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Henry Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Kate Brescol

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Co.

14 Informant James Silk (Address) 3023 Eastern Ave

15 Filed June 27 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 10, 1929, to June 25, 1929.

that I last saw h alive on June 24, 1929.

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Contributory (Secondary) Myocardial insufficiency (duration) yrs 5 mos 15 ds.

(duration) yrs. 1 mos. 25 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Signs & symptoms

(Signed) Edw A Benson M. D.

19/1929 (Address) Overlea Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore County DATE OF BURIAL 6/28 1929

20 UNDERTAKER Mr Cook ADDRESS 1279 Penn Ave

INSTRUCTION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47219

REGISTERED NO. 179 E 47219

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Balto City Hospital St. 12-19 Ward)

2-FULL NAME Louis Nitdorff

(a) RESIDENCE NO. 1537 N Charles St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Helen Nitdorff

6 DATE OF BIRTH (month, day, and year) Aug 25 1871

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
56	10	1	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Real Estate
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Own Business

9 BIRTHPLACE (city or town)
(State or country) Maryland

PARENTS

10 NAME OF FATHER Louis Nitdorff

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

14 Informant Helen M Nitdorff
(Address) 1537 N Charles St

15 Filed 2 11 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest thereon and from the evidence obtained by said (Inquest, autopsy or inquiry.) investigation find that said deceased came to (Inquest, autopsy or inquiry) his death on the day stated above.
The CAUSE OF DEATH* was as follows:
30 Hours
Horribly Burns

(duration) yrs. 1 mos. 5 ds.
CONTRIBUTORY (Secondary) Broncho Pneumonia

(duration) yrs. mos. 5 ds.
18 Where was disease contracted If not at place of death? 1437 N Charles
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Clinical
(Signed) James M Fenton, M. D.
6-27, 1929 (Address) 7002 Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Frederick
DATE OF BURIAL 6/28 1929
20 UNDERTAKER W M Cook
ADDRESS 1711 Arch

important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47220

CERTIFICATE OF DEATH

161-001

E 47220

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 4303 Glenmore Ave. 26-42 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles E Hochhaus

(a) RESIDENCE NO. 4303 Glenmore St. Ave Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Infant

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Infant

6 DATE OF BIRTH (month, day, and year): June 26-1929

7 AGE — Years — Months — Days — IF LESS than 1 day 34 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particolar kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town): Baltimore

(State or country): Maryland

PARENTS

10 NAME OF FATHER: Charles E Hochhaus

11 BIRTHPLACE OF FATHER (City or town)

(State or country): Maryland

12 MAIDEN NAME OF MOTHER: Nellie Genevieve Young

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Maryland

14 Informant: Mrs Charles E Hochhaus

(Address): 4303 Glenmore Ave

15 Filed 6/28 19 29

Registrar

JUN 28 1929

C. HANSON POPE M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

June 26-1929

17 I HEREBY CERTIFY, That I attended deceased from June 26 19 29 to June 26 19 29

that I last saw h alive on June 26 19 29

and that death occurred, on the date stated above, at 3 P. M.

The CAUSE OF DEATH* was as follows:

Prematurity

(1 month Child)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Prematurity (1 month Child)

(duration) yrs. mos. ds.

18 Where was disease contracted —

If not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Morris B Freund M. D.

19 29 (Address) Hamilton Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — Date of Burial: June 28 1929

20 UNDERTAKER: Jos. J. Derr — ADDRESS: 156 N. Luzerne

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

225034
E 47221
1-PLACE OF DEATH

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

7-4-661

E 47221
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 2-4 WARD)

2-FULL NAME Max Rosenbaum

(a) RESIDENCE NO. 1703 Eastern Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? 40 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Yetta Rosenbaum

6 DATE OF BIRTH (month, day, and year): Sept 15-1870

7 AGE — Years: 57 — Months: 9 — Days: 12 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: —

(b) General nature of industry, business, or establishment in which employed (or employer): Tailor

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Poland

PARENTS

10 NAME OF FATHER: Abraham

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland

12 MAIDEN NAME OF MOTHER: Minnie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland

14 Informant: Records.

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 7-29 1929

C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6-27-1929

17

I HEREBY CERTIFY, That I attended deceased from 4-5-, 1929, to 6-27-, 1929, that I last saw him alive on 6-27-, 1929, and that death occurred, on the date stated above, at 1 00 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage — Paralysis R Side — Lung abscess R lower lung.

(duration) yrs. 2½ mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. Briggs M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Washington Rd

DATE OF BURIAL: 6-28-29

20 UNDERTAKER: Jack Lewis

ADDRESS: 1139 E Baltimore St

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47222

CERTIFICATE OF DEATH

31

E 47222

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2912 Ridgewood Ave. St. 15-67 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Abraham Sauber

(a) RESIDENCE NO. 2912 Ridgewood Ave. St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., If foreign birth? 27 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

6 If married, widowed or divorced, HUSBAND of (or) WIFE of Fannie Sauber

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Solomon Sauber

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

11 Informant Jack Lewis

(Address) 1439 E. Baltimore St

15 Filed JUN 29 1929 H. A. Jones M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/27/29

17 I HEREBY CERTIFY, That I attended deceased from June 1 1929 to June 27 1929

that I last saw him alive on the 17 June 1929

and that death occurred, on the date stated above, at 3 20 a.m.

The CAUSE OF DEATH* was as follows:

myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis, Emphysema

Interval. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Nathan Wilkofsky M. D.

(Address) 1101 Edwards

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale

DATE OF BURIAL 6/30/29

UNDERTAKER B. Jack Lewis 1439 E Balto St

ADDRESS

Spec.—2-29-28—L. F. S.—500 Bks.

E 47223 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 47223

REGISTERED NO.

1—PLACE OF DEATH 2102 E. Balto St

CITY OF BALTIMORE: (No. Incurable Home ST., 6-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Zippa Grossman

(a) RESIDENCE NO. 2138 E. Balto street WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 15 Dys How long in U. S., if foreign birth? 15 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	White	Widow

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Hyman Grossman

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis

(Address) 1439 E. Balto st

15 Filed [illegible] C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/27/29

17 I HEREBY CERTIFY, That I attended deceased from Jan 19 29, to June 27, 19 29, that I last saw h[illegible] alive on June 27, 19 29, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

myocardial insufficiency

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) arteri-sclerosis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) 1840 Eutaw Place.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Rosedale	6/28/29 19
20 UNDERTAKER	ADDRESS
Jack Lewis	1439 E. Balto st

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47224

CERTIFICATE OF DEATH

90

E 47224

1—PLACE OF DEATH

REGISTERED NO. 8-45

CITY OF BALTIMORE: (No. Mercy Hospital ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Clara Hahn

(a) RESIDENCE NO. 2763 Chesterfield Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of L. E. Hahn

6 DATE OF BIRTH (month, day, and year) Jan 1st 1895

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34	5	26.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Aug. Bruggemann

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Koegh[illegible]eider

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore

14 Informant L. E. Hahn

(Address) 2763 Chesterfield Ave

15 Filed ..., 19 C. HAMILTON SIMS, M. D. Registrar

28 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/27/29

17 I HEREBY CERTIFY, That I attended deceased from 5/30/29, 19..., to 6/27/29, 19...

that I last saw h C. alive on 6/27/29, 19

and that death occurred, on the date stated above, at 12 M. m.

The CAUSE OF DEATH* was as follows:

Rheumatic Cardio Vascular Disease

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Decompensation

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) J. S. Winstead, M. D.

19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Comm	Jan 29 1929
20 UNDERTAKER	ADDRESS
Frank A Fink	915 N. Gay St

Spec.—1-10-21—M&T—1500 Blks.

726600
E 47225

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1 32 E 47225

1-PLACE OF DEATH

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 19 WARD)

2-FULL NAME Alva Gatsey

(a) RESIDENCE No. Harbour View Md ST., Colgate P.O (Box 485), Balto. WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2½ mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 2nd 1925

7 AGE: 3 Years 9 Months 25 Days | If LESS than 1 day, ... hrs. or ..... min.

4

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Wilford

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Edna Lacy

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Records
(Address) JOHNS HOPKINS HOSPITAL

15 JUN 28 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27 1929

17

I HEREBY CERTIFY, That I attended deceased from June 24. 1929. to June 27. 1929.
that I last saw him alive on June 27. 1929.
and that death occurred, on the date stated above, at 5.10A m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) 6 weeks yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? in home

Did an operation precede death? No Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) F. C Goodwin M. D.

6/27 1929 (Address) J. H. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem — DATE OF BURIAL: June 29 1929

20 UNDERTAKER: Geo M Smith & Son — ADDRESS: Gilmor & Co

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47226

CERTIFICATE OF DEATH.

101-001

E 47226

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 924 Virginia Ave., WARD) 16 2 2

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Stephen Deppino

(a) RESIDENCE No. 924 Virginia Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Wh.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: X

6 DATE OF BIRTH (month, day, and year): Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	44	9	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Un

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Un

14 Informant: Harry Deppino

(Address) 924 Lucille St.

Filed 28 1929, 19 H. HANSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 24 1929

17 I HEREBY CERTIFY, That I attended deceased from April 15, 1929, to June 24, 1929, that I last saw h— alive on June 25, 1929, and that death occurred, on the date stated above, at 1 00 m

The CAUSE OF DEATH was as follows:

Lobar Pneumonia following Influenza complicated by Pleurisy and congested lungs

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Pulmonary congestion complicating Pneumonia (duration) yrs. 1/2 mos. — ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of No

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) H. H. Hall, M. D.

, 19 (Address) 4266 Reed

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery

DATE OF BURIAL: 6-28 1929

20 UNDERTAKER: Jos. A. Lively

ADDRESS: 409 N. Mount St.

Spec.—1-12-23—M&T—500 Blks.

E 47227 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

101-001

E 47227

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 634 N. Chester St.) (WARD) 7-13

REGISTERED No. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank A. Meisel

(a) RESIDENCE No. 634 N. Chester St. (ST.) ..... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna K. Meisel

6 DATE OF BIRTH (month, day, and year) Aug 15 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	68	10	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stockkeeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Casper Meisel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER V.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Lola Meisel
(Address) 634 N. Chester St

15 Filed JUN 28 1929 Registrar C. HARRISON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27 1929

17 I HEREBY CERTIFY, That I attended deceased from June 24, 1929, to June 27, 1929, that I last saw h alive on June 27, 1929 and that death occurred, on the date stated above, at 8:30 A. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 3 ds.
CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis.
(duration) 5 yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Frank Lloyd M. D.
June 27 1929 (Address) 2005 E. Monument St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL 6-25 1929

20 UNDERTAKER L. J. Rusk — ADDRESS 6493 Sefton Ave

Spec.—12-9-25—A Co.—200 Bks.

E 47228

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

74 001

E 47228
REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3401 Carlisle Ave. 15-64 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Kesterson

(a) RESIDENCE NO. 3401 Carlisle Ave. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 ~~Male~~ Female

4 Color or Race White

5 Single, Married, Widowed, or Divorced. (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Thomas F. Kesterson

6 DATE OF BIRTH (month, day, and year) February 7th 1856

7 AGE

Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
73	4	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Delta

(State or country) Pa.

PARENTS

10 NAME OF FATHER Joseph Adams

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Winifred Irvine

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) England

14 Informant Paul E. Kesterson

(Address) 3401 Carlisle Ave.

15 Filed ..... 19 ..... Registrar

G. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26th 1929

17 I HEREBY CERTIFY, That I attended deceased from June 24 1929, to June 26 1929, that I last saw h[illegible] alive on June 26 1929, and that death occurred, on the date stated above, at 7.45 m.

The CAUSE OF DEATH was as follows:

Cerebral Hemorrhage with preceding paralysis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY —

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Wesley Cole, M. D.

(Address) 2702 Hampden Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Cathedral Cemetery — Date of Burial 6/29 1929

20 UNDERTAKER — Chas. L. Frauenhoz — ADDRESS 11 W. Mt. Royal Ave.

very important. See instructions on back of certificates.

28 1929

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47229

CERTIFICATE OF DEATH

+ 90

E 47229

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. University Hospital 4-30 ST., WARD)

2—FULL NAME Jessie Jones

(a) RESIDENCE NO. Lutherville, Md ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: 1

4 COLOR OR RACE: C.

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm H. Jones

6 DATE OF BIRTH (month, day, and year): Mar 6 1873

7 AGE: Years 56 | Months 3 | Days 21 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Wm. H. Jones

(Address) Lutherville Md.

FILED JUN 28 1929 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/27/29

17

I HEREBY CERTIFY, That I attended deceased from 6/26, 1929, to 6/27, 1929, that I last saw her alive on 6/27, 1929 and that death occurred, on the date stated above, at 11 30 a.m.

The CAUSE OF DEATH* was as follows:

Arterio-sclerotic heart disease; myocardial failure;

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Charles E. Hill, M. D.

6/27 1929 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary — DATE OF BURIAL: June 29 1929

20 UNDERTAKER: Mrs. R. G. Elbert — ADDRESS: 1725 Eastlan

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47230

CERTIFICATE OF DEATH

45 E 47230

1—PLACE OF DEATH Caroline & Hamp Sts

REGISTERED NO. 25-15

CITY OF BALTIMORE: (No. St. Joseph Hospital ST. 25 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank J. Brady

(a) RESIDENCE NO. 518 Mandeville ST., Baltimore Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 37 yrs. 7 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elsie M. Brady

6 DATE OF BIRTH (month, day, and year) Nov 26 1891

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	37	7	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Foreman

(b) General nature of industry, business, or establishment in which employed (or employer) Chemical Co

(c) Name of employer Commercial Pigments Corp.

9 BIRTHPLACE (city or town) Baltimore, Md (State or country)

PARENTS

10 NAME OF FATHER Joseph C. Brady

11 BIRTHPLACE OF FATHER (city or town) Richmond (State or country) Va.

12 MAIDEN NAME OF MOTHER Elizabeth Wagel

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Elsie M. Brady

(Address) 518 Mandeville Balto.

JUN 29 1929 [illegible] M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/26/29

17 I HEREBY CERTIFY, That I attended deceased from 6/5/29, 19..., to 6/26/29, 19..., that I last saw him alive on 6/26/29, 19... and that death occurred, on the date stated above, at 7P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of rectum

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) cachexia

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Course

(Signed) A B Hendrix, M. D.

, 19 29 Address Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem.	June 29 1929
20 UNDERTAKER John F. Denny	**ADDRESS** 715 Light St

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47231

E 47231

CERTIFICATE OF DEATH

1—PLACE OF DEATH Md General Hosp. REGISTERED NO. 12-49

CITY OF BALTIMORE: (No. Howard & Madison ST. 12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ann Kipp

(a) RESIDENCE NO. 301 Northway ST., Guilford WARD
(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. 3 mos. 10 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar 16, 1919

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
10	3	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) School Girl

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER John M. Kipp

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Serena Obrecht

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Hosp. Record (Address)

15 Filed JUN 28 1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26, 1929

17 I HEREBY CERTIFY, That I attended deceased from 6/23, 1929, to 6/26, 1929, that I last saw h[illegible] alive on June 26, 1929 and that death occurred, on the date stated above, at 8:15 a.m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of June 23, 1929

Was there an autopsy? Yes

What test confirmed diagnosis? Operation

(Signed) W. E. Kupelmeier M. D.

6/26, 1929 (Address) Md General Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	June 29 1929

20 UNDERTAKER John F. Denny ADDRESS 7/5 Light St

Spec.—2-29-28—L. F. S.—500 Bks.

E 47232 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 47232

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3135 Virginia Ave ST., 27-56 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Edna V Prestì

(a) RESIDENCE NO. 3135 Virginia ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of Samuel S Prestì

6 DATE OF BIRTH (month, day, and year) Sept 7 1897

7 AGE 31 Years 9 Months 10 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Edw Schneider

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md
(State or country)

12 MAIDEN NAME OF MOTHER Carrie Hellwege

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md
(State or country)

14 Informant Mrs Edw Schneider

(Address) 3136 Woodland ave

15 Filed JUN 29 1929 H. KELSON JONES, M. D. Registrar

N 231929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27 1929

17 I HEREBY CERTIFY, That I attended deceased from May 1st 1929, to June 27 1929, that I last saw h er alive on June 26 1929 and that death occurred, on the date stated above, at 1.10 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 4 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Laryngeal T.B.

(duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Undetermined

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Examination

(Signed) C. B. Ewing M. D.

6-27 1929 (Address) 4936 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery — DATE OF BURIAL June 29 1929

20 UNDERTAKER John F Denny — ADDRESS 715 Light St

Cor.—10-10-29—A Co.—100 Bks.

E 47233

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

188-103

E 47233

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2nd Gen Hosp St., 18-26 Ward)

2-FULL NAME Pauline Vogel

(a) RESIDENCE NO. 17 W Lexington St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
F	W	M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of M

6 DATE OF BIRTH (month, day, and year) 6-27-1852

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	77			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) Home
(c) Name of employer

9 BIRTHPLACE (city or town) Germany
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Maryland Nearest
(Address) 47 W Pratt

15 Filed ..... 19 ..... HAMPSON JONES, M. D. Registrar

N 28 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest
(Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows: Hypostatic Pneumonia - the result of a fracture of the neck of the femur of the right side

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) fracture of right femur

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. D. Fraser, M. D.

6-29 1929 (Address) 1923 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	June 29 1929
20 UNDERTAKER George J. Smith	ADDRESS 532 Hollins

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47234 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

3 E 47234

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 504 N. Madeira ST., 7-19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frances Praeger

(a) RESIDENCE NO. 504 N Madeira ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. 10 mos. 24 ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 4 1911

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
17	16	10	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Henry Praeger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Frances Heft

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Frances Praeger
(Address) 504 N Madeira St

15 Filed June 29, 1929 C. HAMPSON JONES, M. D. Registrar

281929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28/29

17 I HEREBY CERTIFY, That I attended deceased from July 17 1929 to June 28th 29
that I last saw her alive on June 24th 1929
and that death occurred, on the date stated above, at 8:30 A m.

The CAUSE OF DEATH* was as follows:

Pthisis Pulmonalis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Marasmus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Sidney Hanner, M. D.

June 28th, 1929 (Address) 504 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	July 1 1929
20 UNDERTAKER	ADDRESS
Hurd & Hudson	1906 Edmondson

Cor.—10-10-29—A Co.—100 Bks.

E 47235

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

194 E 47235

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Pronounced deadat
City of Baltimore: (No. St. Josppn Hospital St., 10-14 Ward)

2-FULL NAME Willian Tulsa Spears

(a) RESIDENCE NO. 1007 Wilcox St., Ward
(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	black	Widower

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	45			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House
(b) General nature of industry, business, or establishment in which employed (or employer) Painter
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) British West Indies

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) "
(State or country)

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) "

14 Informant Ella Cooper
(Address) 521 Hanford Ave

15 Filed ..... 19.. (C. HAMPSON JONES, M. D.) Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 24/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:
Probably Cardiac Renal Disease plus Heat Prostration

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Collins, M. D.

6/27/29 (Address) 505 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
asbury cemetery	June 28 1929
20 UNDERTAKER Edward Bryan	ADDRESS 1631 orleans St

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47236

CERTIFICATE OF DEATH

31 E 47236

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3007 (St.) Glenmore Ave (Ward) 43

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Cynthia M. Hoerr

(a) RESIDENCE NO. 3007 (St.) Glenmore ave. (Ward)

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Louis M. Hoerr

6 DATE OF BIRTH (month, day, and year) Dec. 28th 1883

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	45	5	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Co.
(State or country) Maryland

PARENTS

10 NAME OF FATHER Frederick Neidhardt

11 BIRTHPLACE OF FATHER (city or town) Balto. Co.
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Elvina Reuter

13 BIRTHPLACE OF MOTHER (city or town) Balto. Co.
(State or country) Maryland

14 Informant Louis M. Hoerr
(Address) 3007 Glenmore Ave.

15 Filed ... 19... C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26th 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 28, 1928, to June 26, 1929, that I last saw h[e] alive on June 26, 1929 and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Phthisis Pulmonus

(duration) 5 yrs mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Gustave A Zint, M. D.

6/27, 1929 (Address) Overlea.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Jerusalem Cemetery	June 29 1929

20 UNDERTAKER Frederick Lassahn Sons ADDRESS Fullerton

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47237

CERTIFICATE OF DEATH

129 E 47237

1—PLACE OF DEATH German Aged Home

CITY OF BALTIMORE: (No. Baltimore & Payson ST. 20-27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Christine Kestner

(a) RESIDENCE NO. German Aged Home ST., Baltimore & Payson WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) October 13, 184[illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	8	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Waldeck

(State or country) Germany

PARENTS

10 NAME OF FATHER Johann Bomm

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Wagner

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Germany

14 Informant Records German Aged Home

(Address) Baltimore & Payson Sts.

15 6-28 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 28, 1929, to June 28, 1929, that I last saw her alive on June 28, 1929 and that death occurred, on the date stated above, at 9.30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis Hemiplegia

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) R Heller Hemmeter, M. D.

6/28 1929 (Address) 2000 Hollins St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery — DATE OF BURIAL June 29, 1929

20 UNDERTAKER Joseph B Cook — ADDRESS 1003 West Baltimore St.

Cor.—10-10-29—A Co.—100 Bks.

E 47238

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001 E 47238

1-PLACE OF DEATH

City of Baltimore: (No. 1129 Ward St. 21-29 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry E Banks

(a) RESIDENCE NO. 1129 Ward St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 62 yrs. 5 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed or Divorced, (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Annie Banks

6 DATE OF BIRTH (month, day, and year): Sept 3- 1866

7 AGE: Years 62 | Months 9 | Days 24 | IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Lab-
(b) General nature of industry, business, or establishment in which employed (or employer): Lab
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Co - Md

PARENTS

10 NAME OF FATHER: John Banks

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto Co - Md

12 MAIDEN NAME OF MOTHER: Mary Carr -

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Co - Md

14 Informant: Annie Banks
(Address) 1129 Ward

15 Filed ....., 19.... E. HAMPSON JONES, M. D. Registrar

28 1629

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 27 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:*

Apoplexy.

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary)

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas H Brownley, M. D.

June 29, 1929 (Address) 3601 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: 6/29 1929

20 UNDERTAKER: William Cook — ADDRESS: 121 E Saratoga St

important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47239 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001 E 47239

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. South Balto, Gen. Hosp. St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emily Augusta Pinkerton

(a) RESIDENCE NO. 4718 Alhambra Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of — No

6 DATE OF BIRTH (month, day, and year) 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
7	7 yrs.			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Schoolgirl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto. Md. (State or country)

PARENTS

10 NAME OF FATHER John H. Pinkerton

11 BIRTHPLACE OF FATHER (city or town) Balto, Md. (State or country)

12 MAIDEN NAME OF MOTHER Etta Gaynor

13 BIRTHPLACE OF MOTHER (city or town) Balto Md. (State or country)

14 Informant Mother

(Address)

15 4-28-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 4/27/29

17 I HEREBY CERTIFY, That I attended deceased from May 14, 1929, to April 27, 1929, that I last saw h[illegible] alive on April 27, 1929, and that death occurred, on the date stated above, at 7 [illegible] m.

The CAUSE OF DEATH* was as follows:

Pneumonia Lobar, Left

Upper

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Multiple Emboli

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of May 15 1929

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) C. A. Hilligan, M. D.

. 19 (Address) 1213 Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery — DATE OF BURIAL 6/29 19 29

20 UNDERTAKER Mrs Cook — ADDRESS 2178 St Paul

Spec.—1-12-23—M&T—500 Blks.

E 47240

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47240

CERTIFICATE OF DEATH.

31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 707 S. Regester ST. 7-4 WARD)

2-FULL NAME Mrs. Anna Berry

(a) RESIDENCE NO. 707 S. Regester ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W.	married

5a If married, widowed, or divorced HUSBAND of or) ~~WIFE~~ of Frederick Berry

6 DATE OF BIRTH (month, day, and year) Dec. 16, 1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	8	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home Wife

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Max Szczukowski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Mary Studynska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Fredrick Berry

(Address) 707 S. Regester St.

291929 , 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 18, 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb — , 1929, to June 18, 1929

that I last saw h~~er~~ alive on June 18, 1929.

and that death occurred, on the date stated above, at 8:40 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 4-5 mos ds.

CONTRIBUTORY (Secondary) Cardiac failure (Myocarditis)

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? 703 S. Wolfe St

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Isaac H. Trimpler, M. D.

6/18, 1929 (Address) 1101 E. Baltimore.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

St. Stanislaus Cem. June 1 1929

20 UNDERTAKER — ADDRESS

George A. Weber 705 S. Canon St.

Spec.—1-10-21—M&T—1500 Bks.

E 47241 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47241

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. (WARD) 9-4

2-FULL NAME Mary Katsaites

(a) RESIDENCE NO. 757 S Broadway ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7-2-16

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
12	11	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Tony

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greece

12 MAIDEN NAME OF MOTHER Anne

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Greece

14 Informant Rev

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 291929 C. HAMPSON JONES, M. D. Registrar

By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28 1929

17

I HEREBY CERTIFY, That I attended deceased from June 22, 1929, to June 28, 1929,

that I last saw h[illegible] alive on June 28, 1929,

and that death occurred, on the date stated above, at 7 1/2 m.

The CAUSE OF DEATH* was as follows:

Chorea. ~~Septicaemia~~.

Chorea - 2 wk. (duration) ~~Septicaemia 4 days~~ yrs. mos ds.

CONTRIBUTORY ~~(Primary)~~ Rheumatic Fever
(Secondary)

(duration) yrs. 5 mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) F. C. Goodwin, M. D.

4/28/1929 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Sulcidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn cemetery DATE OF BURIAL: June 27, 1929

20 UNDERTAKER: George A. Weber ADDRESS: 703 S. Ann

TION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47242

CERTIFICATE OF DEATH.

90 E 47242

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 2463 Druid Hill Ave St., (Ward) 13-54

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary E. Tinson

(a) RESIDENCE NO. 2463 Druid Hill Ave St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fr.

4 Color or Race: C.

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1879

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
about	50			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Hanford Co Md

PARENTS

10 NAME OF FATHER: Wilson Gilbert

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Unknown

14 Informant: E. Tinson

(Address): 2463 Druid Hill Ave

15 Filed 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/26 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) and that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Duration of Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) J. H. Morrissey M. D.

(Coroner)

6/28 1929 (Address) 3632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Date of Burial 6/29 1929

20 UNDERTAKER: John H. Toadvine ADDRESS 027 Druid Hill Ave

If death occurred in public institution, name it instead of street and number. This item is very important. See instructions on back of certificate. EXACT statement of OCCUPATION is

Spec.—1-10-21—M&T—1500 Bks.

E 47243 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47243

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1133 Argyle Ave ST., 17th WARD)

2-FULL NAME Sarah V. Biagi

(a) RESIDENCE No. 1133 Argyle Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug. 8 1880

7 AGE: Years 48 Months 10 Days 18 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Horace Beal

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Sarah R. Beal

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant (Address): Bertha Beal 1133 Argyle Ave

15 291929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 26 1929

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1929, to June 26 1929.

that I last saw her alive on June 26 1929

and that death occurred, on the date stated above, at 10:20 P.M.

The CAUSE OF DEATH* was as follows:

Chron. Parenchymatous nephritis

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Exhaustion & Coma.

(duration) yrs mos. 3 ds.

18 Where was disease contracted if not at place of death? No.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) Lee H. Lavenbach M. D.

6-27, 1929 (Address) 225 N. Washington Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Cem

DATE OF BURIAL: June 30 1929

20 UNDERTAKER: Samuel H. Hensley

ADDRESS: 928 N. Bond St.

TION is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 47244 (1329)

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 E 47244

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 1-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Jeanette Sturges

(a) RESIDENCE (No.) 933 N. Wolfe ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. 6 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Isaac Sturges

6 DATE OF BIRTH (month, day, and year) 1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work N.W. 27

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John Magruder

11 BIRTHPLACE OF FATHER (city or town) Md (State or country)

12 MAIDEN NAME OF MOTHER Matilda Denty

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 6-29-1929 C. HAMPSON JONES M. D. Registrar

per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27 1929

17 I HEREBY CERTIFY, That I attended deceased from June 17, 1929, to June 27, 1929, that I last saw her alive on June 27, 1929, and that death occurred, on the date stated above, at 12 P. M. Midnight

The CAUSE OF DEATH* was as follows:

Abscess of liver

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Septicaemia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Bethesda Hospital

Did an operation precede death? yes Date of 6-27-29

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Walter W. Eagle M. D.

6-27, 1929 (Address) John Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cem

DATE OF BURIAL 6-30 1929

20 UNDERTAKER Tyson & Wright 1218 N. Eden & Elderry St

ADDRESS

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

90

E 47245

CERTIFICATE OF DEATH

REGISTERED NO. E 47245

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 936 E Preston ST. 9-18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Lindenstruth,

(a) RESIDENCE NO. 936 E Preston ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma M. Lindenstruth

6 DATE OF BIRTH (month, day, and year) Sept 4-1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	9	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Barber

(b) General nature of industry, business, or establishment in which employed (or employer) 5 yrs. 004

(c) Name of employer self.

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Christian Lindenstruth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Emma M Lindenstruth

(Address) 936 E Preston St

15 Filed ..... C. HAMPSON JONES, M. D. Registrar

By .....

29 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27-1929

17

I HEREBY CERTIFY, That I attended deceased from May 15 - 1929, to June 27- 1929, that I last saw him alive on June 27 1929 and that death occurred, on the date stated above, at 6.40 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. 1 mos. 12 ds.

CONTRIBUTORY (Secondary) Oedema Lungs

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) E. Gill Hall, M. D.

June 28 1929 (Address) 1631 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cem. DATE OF BURIAL July 1 1929

20 UNDERTAKER John Merrick ADDRESS 2 to 8 Reliance

Spec.—1-12-23—M&T—500 Bks.

E 47246

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47246

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hospital ST. 23-31 (WARD) 111-8

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Lewis Brown

(a) RESIDENCE No. 169 Winkus Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Brown

6 DATE OF BIRTH (month, day, and year): 1901

7 AGE: Years 28 Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Day

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Wm Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Lavinia Jenkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mary Brown

(Address) 1904 Pennsa ave

15 Filed 6/30, 19 29 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/26, 1929

17 I HEREBY CERTIFY, That I attended deceased from 4/28, 19 29, to 6/26, 19 29, that I last saw h[illegible] alive on 6/26, 19 29, and that death occurred, on the date stated above, at 12 noon.

The CAUSE OF DEATH* was as follows:

Ruptured duodenal ulcer

(duration) yrs. mos 58 ds.

CONTRIBUTORY (Secondary) Duodenal Fistula

(duration) yrs. 1 mos. 7 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? yes Date of 4/28/29

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) B Haus, M. D.

6/26, 19 29 (Address) Provident Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Gilboa Cmtry

DATE OF BURIAL: 6/30 19 29

20 UNDERTAKER: Thomas E. Nelson

ADDRESS 1303 Pressman

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47247

CERTIFICATE OF DEATH

E 47247

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. University Hospital WARD)

2—FULL NAME Elizabeth Farrell

(a) RESIDENCE NO. 1427 Mt. Royal Ave, WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	married

a If married, widowed, or divorced (or) WIFE of Clifton S Farrell

6 DATE OF BIRTH (month, day, and year) May 10 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	1	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER George Christopher Lee

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Emma Redstreak

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Emma Farrell
(Address) 1427 Mt. Royal Ave

15 JUN 29 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/29/29

17 I HEREBY CERTIFY, That I attended deceased from 6/22 1929 to 6/29 1929

that I last saw h alive on 6/29 1929

and that death occurred, on the date stated above, at 12:30 Am.

The CAUSE OF DEATH* was as follows: Carcinoma Liver

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 6/22/29

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) E. E. Little, M. D.

1929 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Chestertown Md	7/1 1929
20 UNDERTAKER Wm Cook	ADDRESS 1217 St Paul

Spec.—2-29-28—L. F. S.—500 Bks.

E 47248

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001 E 47248

1—PLACE OF DEATH

REGISTERED NO. 1567

CITY OF BALTIMORE: (No. 3705 Barrington Road ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Rebecca Aldridge

(a) RESIDENCE NO. 3705 Barrington Road ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of William R. Aldridge

6 DATE OF BIRTH (month, day, and year) Sept-11-1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	9	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Chestertown
(State or country) Maryland

PARENTS

10 NAME OF FATHER Daniel Bowers

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Augusta M. Dodd

13 BIRTHPLACE OF MOTHER (city or town) Chestertown
(State or country) Maryland

14 Informant Mrs. Gladys A. Wilkinson (daughter)
(Address) 3705 Barrington Road

15 2-9 1929 C. HAMPSON JONES, M. D.
(Registrar)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28th 29

17 I HEREBY CERTIFY, That I attended deceased from May 6th, 1929, to June 27-, 1928. that I last saw her alive on June 27-29, and that death occurred, on the date stated above, at 12.17 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemiplegy

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Isaac E. Dickson, M. D.

June 28 1929 (Address) 3055 W. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Chestertown Md.	July 1 29 19

20 UNDERTAKER ADDRESS

Edwards & Mowen Co. Balto, Md.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47249

CERTIFICATE OF DEATH.

44 E 47249

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bon Secours Hospital ST. (WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Santacroce

(a) RESIDENCE NO. 390 Forrest ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Marie A. Santacroce

6 DATE OF BIRTH (month, day, and year) 9/30 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40	8	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Confectioner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Giovani Santacroce

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Giuseppa Scandaliato

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Josephine Santacroce
(Address) 390 Forrest st.

15 291929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/28 1929

17 I HEREBY CERTIFY, That I attended deceased from 5/23, 1929, to 6/28, 1929

that I last saw him alive on 6/27, 1929,

and that death occurred, on the date stated above, at 3.30 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(duration) yrs. ? mos ds.

CONTRIBUTORY (Secondary) nitis and fistula

(duration) yrs. mos. 11 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? Yes No Date of 5/27/29

Was there an autopsy?

What test confirmed diagnosis? Operation

(Signed) Theo. E. Stacy Jr. M. D.

, 19 (Address) Bon Secours Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem.

DATE OF BURIAL 7/1 1929

UNDERTAKER George J. Ruth

ADDRESS 1735 Harford Ave

TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 47250

HEALTH DEPARTMENT—CITY OF BALTIMORE

74-001

E 47250

CERTIFICATE OF DEATH

1-PLACE OF DEATH Pronced Dead at

City of Baltimore: (No. Balto City Hospital St. 26-37 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME James P. Clark

(a) RESIDENCE No. 3819 Mt Pleasant St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	white	Widower

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Sarah Byrnes Clark

6 DATE OF BIRTH (month, day, and year) Mar [illegible] 1861

7 AGE	Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
	68	3		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Baltimore City Jail

9 BIRTHPLACE (city or town)
(State or country) Ireland

PARENTS

10 NAME OF FATHER Patrick Clark

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Mrs Green
(Address) 3819 Mt Pleasant St

15 Filed C. HAMPSON JONES, M. D. Registrar
By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry) find that said deceased came to [illegible] death on the day stated above.
The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) Instant yrs. mos. ds.

CONTRIBUTORY (Secondary) [illegible]

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Jungle Ave & Baseline ?
Did an operation precede death? [illegible] Date of
Was there an autopsy? No
What test confirmed diagnosis? Inferred
(Signed) James M Denton M. D.
6-27-1929 (Address) 700 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oaklawn Cemetery	July 1 1929
20 UNDERTAKER John A. Moran	ADDRESS 3000 E. Balto

291929

If DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 47251 HEALTH DEPARTMENT—CITY OF BALTIMORE **E 47251**

CERTIFICATE OF DEATH 129

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3400 Noble ST. 26 WARD) 26-39

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frederick Wiedecke Jr.

(a) RESIDENCE NO. 3400 Noble ST., 26 WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Regina a. Wiedecke

6 DATE OF BIRTH (month, day, and year) Sept. 11th 1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	9 10	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Store Keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Frederick Wiedecke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Kerner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Regina a. Wiedecke

(Address) 3400 Noble St.

15 291929 C/S HAMPSON JONES, M. D. Registrar

Dec 28 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27th 29

17 I HEREBY CERTIFY, That I attended deceased from 1/1, 19 29, to June 27, 19 29

that I last saw h alive on June 10, 19 29

and that death occurred, on the date stated above, at 7 30 P. m.

The CAUSE OF DEATH* was as follows: Myocarditis Chr

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Industrial Neph

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) D. J. Fraim, M. D.

6 28, 19 (Address) 3939 Mc Elderry

29

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	Jul 1 19 29
20 UNDERTAKER Kelly & Jaite Inc.	ADDRESS 405 N. Wolfe St

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47252

CERTIFICATE OF DEATH

109-82

E 47252

1—PLACE OF DEATH

REGISTERED NO. 10-37

CITY OF BALTIMORE: (No. Sydenham Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME MICHAEL FETZ

(a) RESIDENCE NO. 408 S. Oldham ST. 26 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. 0 mos. 18 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): June 10, 1926

7 AGE — Years: 3 | Months: 0 | Days: 18 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer): Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Michael Fetz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Christine Lunz

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: Christine Fetz

(Address): 408 S. Oldham St

15 Filed 6-29 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 28, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 14, 1929, to June 28, 1929.

That I last saw h alive on June 28, 1929

and that death occurred, on the date stated above, at 12 15 p. m.

The CAUSE OF DEATH* was as follows:

Streptococcic Septic Sore Throat

(duration) 0 yrs. 0 mos. 28 ds.

CONTRIBUTORY (Secondary) Retropharyngeal Abscess & Bronchopneumonia (duration) 0 yrs. 0 mos. 10 ds.

18 Where was disease contracted if not at place of death? 408 S. Oldham St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Addison Craft Isley M. D.

6-28 1929 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus Cemetery	July 1st 1929
20 UNDERTAKER	ADDRESS
Lilly & Gilbert Inc	40 E. Lanvale St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47253

REGISTERED NO. 8 8 E 47253

1-PLACE OF DEATH

City of Baltimore: (No. 213 N. Luzerne Ave. St. 6-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME WILLIAM WEBER

(a) RESIDENCE NO. 213 N. Luzerne Ave. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Georgia Weber

6 DATE OF BIRTH (month, day, and year) February 4, 1878

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	51	4	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Baker
(b) General nature of industry, business, or establishment in which employed (or employer) Retired 2 years
(c) Name of employer Ward Baking Co.

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Philip Weber

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Katherine Schuchman

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mrs. Georgia Weber (Wife)
(Address) 213 N. Luzerne Ave.

15 Filed ..... 19 .... HAMPSON JONES, M. D. Registrar

6-29-1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27, 1929

17 I HEREBY CERTIFY, That I ~~visited and attended~~ the remains described above, held an ~~Coroner's~~ Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
autopsy or inquiry find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

(a) Cardio Sclerosis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Contusion of Face

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —
Did an operation precede death? — Date of —
Was there an autopsy? —
What test confirmed diagnosis? By Examination
(Signed) H. C. Slades M. D.
19 (Address) 173 N. Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL June 29 19 29

20 UNDERTAKER Henry Sander & Sons, Inc.

ADDRESS BALTIMORE ST. & BROADWAY.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

(Pollack)

E 47254

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

117 E 47254

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Russell S. Pollock

(a) RESIDENCE NO. 2106 Harford Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M.	W.	Sing'l

6a If married, widowed, or divorced HUSBAND of (or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) Oct 7, 1908

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
20	8	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer) Office

(c) Name of employer Carl Lowrey Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Henry Pollock

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Laura M. Nauss

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore.

14 Informant Sister, Blanche Pollock

(Address) 2106 Harford Ave.

15 291929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/29/29

17 I HEREBY CERTIFY, That I attended deceased from 6/22, 1929, to 6/29, 1929, that I last saw h in alive on 6/29, 1929 and that death occurred, on the date stated above, at 10:15 P m.

The CAUSE OF DEATH* was as follows:

Acute Appendicitis

CONTRIBUTORY (Secondary) Peritonitis (duration) yrs. mos. 2 ds.

Acute (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 6/22/29

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) L. E. Pollock, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cemetery — DATE OF BURIAL: July 1 1929

20 UNDERTAKER: Henry Sander & Sons. Inc. — ADDRESS: Baltimore St & Broadway

Spec.—2-29-28—L. F. S.—500 Bks.

E 47255

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

16-02

E 47255

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 808 W Ostend ST. 21-29 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Bernice Waters

(a) RESIDENCE NO. 808 W. Ostend ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F.	Col.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 13 1925

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	4	5 4	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Carlton Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Ellen Waters

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Ellen Waters
(Address) 808 W. Ostend

15 Filed 30 1929 H. Wilkins Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/27/29

17 I HEREBY CERTIFY, That I attended deceased from 6/16/ 29, to 6/27/ 29, that I last saw her alive on 6/27/ 29, and that death occurred, on the date stated above, at 7.30 P m.

The CAUSE OF DEATH* was as follows:

Tubercle Enteritis

CONTRIBUTORY (Secondary) Bacillus Tuberculosis (duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? none (duration) yrs. mos. 10 ds.

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

, 19 (Address) 9050 Shady G.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery — DATE OF BURIAL June 30 1929

20 UNDERTAKER Mrs. Kate R. Williams — ADDRESS 322 S. Schroeder St

Spec.—1-12-23—M&T—500 Blks.

E 47256

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 47256

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1527 Argyle av ST.) (WARD) 11-20

2-FULL NAME Annie E. Gould

(a) RESIDENCE NO. 1527 Argyle av ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jno. B. Gould

6 DATE OF BIRTH (month, day, and year) March 14, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	60	3	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry H. Webb

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary J. Johns

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant John B. Gould

(Address) 1527 Argyle ave

15 Filed 19 C. HARRISON JONES, M. D. Registrar

N 361929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27, 1929.

17 I HEREBY CERTIFY, That I attended deceased from June 17, 1929. to June 27, 1929. that I last saw h[illegible] alive on June 27, 1929. and that death occurred, on the date stated above, at 10.15 m.

The CAUSE OF DEATH* was as follows:

Aortic insufficiency

(duration) 1 yrs. — mos — ds.

CONTRIBUTORY (Secondary)

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) F. K. Pelton, M. D.

, 19 (Address) 812 Hamilton Ter.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL June 29 1929

20 UNDERTAKER Mrs. Katie R. Williams

ADDRESS 322 N. Schroeder St.

THIS IS very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 47257

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001

E 47257

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St. 18-N Ward)

2-FULL NAME Emma Griffin

(a) RESIDENCE NO. 939 W. Saratoga St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: Colored

5 Single, Married, Widowed or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct 1 - 1928

7 AGE: Years | Months: 8 | Days: 28 | IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country): Balto. Md

PARENTS

10 NAME OF FATHER: Robert Griffin

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Clara Isaacs

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Md

14 Informant: Mrs Clara Griffin
(Address) 939 W. Saratoga St

Filed: 19

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 29 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Acute Bronchitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Augustus Zelley, M. D.

6/29 1929 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemetery — DATE OF BURIAL: July 1, 1929

20 UNDERTAKER: Mrs Katie R. Williams — ADDRESS 322 N. Schroeder St

OF DEATH is plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

✓ E47258

E 47258

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 47258

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hospital (ST.) 15-26 (WARD)

2-FULL NAME Mrs Lena Rosenberg.

(a) RESIDENCE NO. 1910 N. Pulaski ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? 24 yrs. mos ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: w

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ellis Rosenberg

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE: Years 44 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Benj Fox

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Mary Sandler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Ellis Rosenberg (Address) 1910 N Pulaski St

15 Filed 30 1929 C. HAMPSON JONES, M. D. Registrar

Fee [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 6/28 1929

17 I HEREBY CERTIFY, That I attended deceased from 6/19, 1929, to 6/28, 1929, that I last saw her alive on 6/28, 1929, and that death occurred, on the date stated above, at 5:10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis.

(duration) 5 yrs. mos ds.

CONTRIBUTORY (Secondary): Uremia.

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. E. Goodman, M. D.

6/29, 1929 (Address) Sinai Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale | DATE OF BURIAL: 6/30 1929

20 UNDERTAKER: Jack Lewis | ADDRESS: 1439 E Balto St

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47259

CERTIFICATE OF DEATH

129

E 47259

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1704 Ellsworth ST., 8-17 WARD)

2—FULL NAME Flora Lee Geary

(a) RESIDENCE NO. 1704 Ellsworth ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE C.

5 Single, Married, Widowed, or Divorced (write the word) S.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 24 1919

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	10	5	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Camden (State or country) S. C.

PARENTS

10 NAME OF FATHER Tucker Geary

11 BIRTHPLACE OF FATHER (city or town) S. C. (State or country)

12 MAIDEN NAME OF MOTHER Ollie Hayson

13 BIRTHPLACE OF MOTHER (city or town) S. C. (State or country)

14 Informant Ollie Geary

(Address) 1704 Ellsworth

15 Filed ..... 19 ..... Registrar

JUN 30 1929 HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26 1929

17

I HEREBY CERTIFY, That I attended deceased from June 22, 1929, to June 26, 1929, that I last saw h[illegible] alive on June 25, 1929, and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Mitral Insufficiency

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumococcus Nephritis

Terminal. (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? NO Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) R. G. Elliott, M. D.

June 27, 1929 (Address) 1424 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Calvary	June 30th 1929
20 UNDERTAKER Mrs. R. G. Elliott	ADDRESS 1725 Ashland

Spec.—1-10-21—M&T—1500 Bks.

E 47260 15

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47260

CERTIFICATE OF DEATH.

118-002

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. 9-18 (WARD)

2-FULL NAME Adelaide Johnson

(a) RESIDENCE NO. 1924 Asquith ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) September, 1908

7 AGE: Years 21 Months ..... Days ..... If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Gen. Housework

(b) General nature of industry, business, or establishment in which employed (or employer): 010

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Wm Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Fannie Thornton

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Parents

(Address) JOHNS HOPKINS HOSPITAL

Filed JUN 30 1929 HAROLD JONES, M. D. Registrar

Per .....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29 1929

17 I HEREBY CERTIFY, That I attended deceased from June 21, 1929 to June 29, 1929.

that I last saw her alive on June 29, 1929,

and that death occurred, on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Post-oper. Mesenteric Thrombosis
Paralytic Ileus
Terminal Broncho pneumonia

(duration) ..... yrs. ..... mos 3 ds.

CONTRIBUTORY (Secondary) Intestinal Obstruction.

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Johns Hopkins Hosp.

Did an operation precede death? Yes Date of June 25/29

Was there an autopsy? Yes.

What test confirmed ~~diagnosis~~? Autopsy.

(Signed) T. Gordon Douglas M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: June 30/29

20 UNDERTAKER: Mrs R. G. Elliott

ADDRESS: 1720 Eutaw

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47261

CERTIFICATE OF DEATH

31

REGISTERED NO. E 47261

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Baltimore City Hospitals (ST.) 22-31 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ben Parker

(a) RESIDENCE NO. 718 Bevan st. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred, yrs. Unknown mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Oklahoma

PARENTS

10 NAME OF FATHER Pink Parker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mexico

12 MAIDEN NAME OF MOTHER Martha ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) India

14 Informant Hospital Records

(Address)

15 Filed ..., 19.. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 25, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1929, to June 25, 1929, that I last saw him alive on June 25, 1929 and that death occurred, on the date stated above, at 3.30 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical and lab.

(Signed) Henry C Smith M. D.

6-26-, 1929 Address Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Potomac Cem. DATE OF BURIAL 7/1/29.

20 UNDERTAKER R. L. Parham ADDRESS 827 Bl...

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

47262

CERTIFICATE OF DEATH

90 E 47262

1—PLACE OF DEATH — REGISTERED NO. 15-65

CITY OF BALTIMORE: (No. 4019 Norfolk Ave., ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Zelda Friedman

(a) RESIDENCE NO. 4019 Norfolk Ave. ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2½ yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Israel Friedman

6 DATE OF BIRTH (month, day, and year) Unknown 1861

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68	-	-	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant J. Lewis
(Address) 1432 E Balto. St.

15 Filed 6-30-1929 H. A. Bloom JONES, M. D. Registrar

UN 301320

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-30-29

17 I HEREBY CERTIFY That I attended deceased from June 20, 1929, to June 29, 1929, that I last saw her alive on June 29, 1929 and that death occurred, on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Thrombosis

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) M. Baylin, M. D.

6/30, 1929 (Address) 2048 Eutaw Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Shaw Mordah	6-30-1929

20 UNDERTAKER Jac. Lewis ADDRESS 1432 E Balto.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47263

CERTIFICATE OF DEATH

90 E 47263

1—PLACE OF DEATH

REGISTERED NO. 20-69

CITY OF BALTIMORE: (No. 2808 W. Mulberry ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Spurley,

(a) RESIDENCE NO. 2808 W. Mulberry ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Carrie Spurley,

6 DATE OF BIRTH (month, day, and year) October 24. 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	8	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Band Saw Operator.

(b) General nature of industry, business, or establishment in which employed (or employer) 086

(c) Name of employer

9 BIRTHPLACE (city or town) Mariette Penna,
(State or country)

PARENTS

10 NAME OF FATHER John Spurley,

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs. Carrie Spurley,
(Address) 2808 W. Mulberry St.

15 Filed JUN 30 1929, 19 C. HAMILTON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY, That I attended deceased from 6-17, 1925, to 6-28, 1929, that I last saw him alive on 6-19, 1929 and that death occurred, on the date stated above, at 8 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Circulatory Hypertension

unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No.

What test confirmed diagnosis? —

(Signed) Chas C. Consor, M. D.

6/29, 1929 (Address) 1101 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn — DATE OF BURIAL 19

20 UNDERTAKER Geo. W. Settle — ADDRESS

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47264

182

CERTIFICATE OF DEATH

E 47264
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Mc Comas St. Piers. St. 23-31 Ward)

2-FULL NAME Clarence E. Marshall. (C)

(a) RESIDENCE NO. 945 S. Sharp St. St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. 8 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) October 27, 1912

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	16	8	0	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Clarence Marshall. (C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Georgia Green. (C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore, Md.

14 Informant Clarence Marshall. (C) father.
(Address) 945 S. Sharp St.

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

N 30 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accidental Drowning while in swimming.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry (C)

(Signed) Otto M. Reinhardt, M. D.

6/29. 1929 (Address) 1019 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary Cemtery

DATE OF BURIAL June 30 1929

20 UNDERTAKER Walter B. Scruggs

ADDRESS 139 W. Hamburg St

IMPORTANT.—Certificate of death must be filled in plain words, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47265 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 47265

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST. 16-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Blanche Miller

(a) RESIDENCE NO. 903 Parish st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1910

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	19			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Housework 070

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Chas. Edward Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records

(Address)

15 Filed JUN 30 1929 JAMES H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 25, 19 29, to June 28, 19 29,

that I last saw her alive on June 28, 19 29,

and that death occurred, on the date stated above, at 5.30 p. m.

The CAUSE OF DEATH* was as follows:

Spontaneous pneumothorax

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Caseous pneumonia

(duration) Unknown mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis Clinical and autopsy

(Signed) Hempstead Smith, M. D.

6-29, 19 29 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn DATE OF BURIAL July 1 1929

20 UNDERTAKER Sam'l. Chase & Son ADDRESS 1100 Madison

Spec.—1-10-21—M&T—1500 Bks.

E 47266 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

x 46 E 47266

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1603 W. Lanvale ST. 16-22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie S. Ferguson

(a) RESIDENCE NO. 1603 W. Lanvale, WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph W. Ferguson

6 DATE OF BIRTH (month, day, and year) Feb 8 1880

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
48	10	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Home 037

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER James Jinkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sophia Butler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Joseph W. Ferguson

(Address) 1603 W. Lanvale Md

15 Filed 1922 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) Apr 8 1922

17 I HEREBY CERTIFY, That I attended deceased from Apr 8 1922, to Apr 8 1922

that I last saw h— alive on Apr 8 1922

and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Pancreas

CONTRIBUTORY (Secondary) (duration) yrs. 6 mos

18 Where was disease contracted if not at place of death? Hardy Sitz

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) H. Lee Ellen M. D.

19 (Address) 924 Mosher

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL West River Md DATE OF BURIAL Apr 9 1922

UNDERTAKER Sam W. Chase & Son ADDRESS 1400 Mosher

TION is very important See instructions on back of certificates.

N 30423 HARRISON JONES, M. D.

Spec.—1-12-23—M&T—500 Bks.

Bowman

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47267

CERTIFICATE OF DEATH.

90

E 47267

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1535 E Madison St., 7-12 WARD)

2-FULL NAME Mildred Bowman

(a) RESIDENCE NO. 1539 E Madison ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: C

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Albert Bowman

6 DATE OF BIRTH (month, day, and year): April 25-1874

7 AGE: Years 55 | Months 2 | Days 1 | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Julia Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Julia Williams

(Address): 1539 E Madison St

15 Filed JUN 30 1929 19 C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 26 1929

17 I HEREBY CERTIFY, That I attended deceased from June 2 . 1929 , to June 26 . 1929 .

that I last saw her alive on June 26 . 1929

and that death occurred, on the date stated above, at 10.40 A m.

The CAUSE OF DEATH* was as follows:

Myocarditis

(duration) yrs. | mos ds.

CONTRIBUTORY (Secondary) Arthritis

(duration) yrs | mos. ds.

18 Where was disease contracted if not at place of death? no

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) [illegible] M. D.

June 27 1929 (Address) 508 [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Fair church Va

DATE OF BURIAL: June 30 1929

20 UNDERTAKER: Milton Davis

ADDRESS: 417 N Eden St

Spec.—2-29-28—L. F. S.—500 Bks.

E 47268

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47268

CERTIFICATE OF DEATH

100-001

1—PLACE OF DEATH Balto City Hosp. REGISTERED NO.

CITY OF BALTIMORE: (No. Balto. Md. ST. 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Antonette Jawlis

(a) RESIDENCE NO. 1742 (Usual place of abode) Eastern Ave ST., WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
54			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. 037

(b) General nature of industry, business, or establishment in which employed (or employer) Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Balto City Hosp (Address) Balto Md

15 Filed 30122 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-28-29

17 I HEREBY CERTIFY, That I attended deceased from 11-10, 1928, to 6-28, 1929

that I last saw h[illegible] alive on 6-28, 1929

and that death occurred, on the date stated above, at 2.30 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Myocardial failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile Psychosis (Cataleptic) Depressed type (duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical findings

(Signed) [illegible] M. D.

6/29, 1929 (Address) Balto City Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary July 1 1929

20 UNDERTAKER J. W. Ozgzewski 1930 Eastern Ave ADDRESS

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47269

CERTIFICATE OF DEATH

9 E 47269

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 315 E Hamburg ST. 24-33 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Grace V Bisser

(a) RESIDENCE NO. 315 E Hamburg ST.
(Usual place of abode) WARD

Length of residence in city or town where death occurred 4 yrs. 1 mos. 1 ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	W	Singl

a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 27/925

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John A Bisser Jr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Josephine A Schelogk

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Curtis Bay Md

14 Informant Mrs Josephine A Bisser
(Address) 315 E Hamburg St

15 Filed ..... 19 .....
C. HAMILTON JONES, M. D.
Per ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28/1929

17 I HEREBY CERTIFY, That I attended deceased from June 27, 1929, to June 28-, 1929, that I last saw her alive on June 28, 1929 and that death occurred, on the date stated above, at 12 P m.

The CAUSE OF DEATH* was as follows:

Bronchio - Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Whooping Cough

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? NO Date of -

Was there an autopsy? NO

What test confirmed diagnosis?

(Signed) Wm D. Smith, M. D.

June 29 1929 (Address) 816 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	July 1 1929

20 UNDERTAKER John T Denny ADDRESS 715 Light St

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47270

CERTIFICATE OF DEATH.

E 47270

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Stone Memorial Hospital St. 26 Ward 26)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME John Philip Murphy

(a) RESIDENCE NO. 5102 Maple Park Ave., St. Franklintown Ward 28

(Usual place of abode)

Length of residence in city or town where death occurred 67 yrs. 11 mos. 9 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 10, 1861

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	67	11	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer North Ave. Market

9 BIRTHPLACE (city or town)

(State or country) Md.

PARENTS

10 NAME OF FATHER John [illegible] Murphy

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Welch

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Ireland

14 Informant Miss Minnie Murphy

(Address) 5102 Maple Park Ave.

Filed JUN 30 1929 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (autopsy or inquiry) thereon and from the evidence obtained by said inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Thrombosis

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) John H. Monahan, M. D.
(Coroner)

6/29, 1929 (Address) 3632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Peters Cemetery Date of Burial July 1 1929

20 UNDERTAKER John F. Dennis ADDRESS 715 Light St

If death occurred in public institution, or from violence, it is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47271

CERTIFICATE OF DEATH

91-00

E 47271

REGISTERED NO. 47-54

1—PLACE OF DEATH Hebrew aged Home

CITY OF BALTIMORE: (No. 2 Lavendale ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mechama Rosenblatt

(a) RESIDENCE NO. 2 Lavendale ST., Green Spring ave WARD Belvedere ave

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., If foreign birth 24 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Israel

6 DATE OF BIRTH (month, day, and year) Unknown.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Isaac Soppenstein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Bailey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Mrs Ida Feldstein

(Address) 1129 E Baltimore st

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30/29

17 I HEREBY CERTIFY, That I attended deceased from March, 1928, to June-30-, 1929, that I last saw h alive on June-30-, 1929 and that death occurred, on the date stated above, at 7 a. m.

The CAUSE OF DEATH* was as follows:

General Arterio Sclerosis

about 5 yrs (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) none (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Herman Seidel, M. D.

6/30, 1929 (Address) ~~Hebrew~~ 2404 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Herring Run — DATE OF BURIAL June 30 19 29

20 UNDERTAKER Sol Levinson & Bro — ADDRESS 1127 E Baltimore st

Spec.—2-29-28—L. F. S.—500 Bks.

E 47272

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49

E 47272

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Alhambra Apts. 3 F. ST. 13-59 WARD)

2—FULL NAME William Theodore

(a) RESIDENCE NO. Alhambra Apts. 3 F. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Wheatfield Theodore

6 DATE OF BIRTH (month, day, and year) Dec. 25th. 1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	50	6	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Insurance

(b) General nature of industry, business, or establishment in which employed (or employer) 07

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Prussia

PARENTS

10 NAME OF FATHER Eli Theodore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Prussia

12 MAIDEN NAME OF MOTHER Sarah Abrams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Prussia

14 Informant Mr. Max Theodore

(Address) Charlestown, W. Va.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29th. 1929.

17 I HEREBY CERTIFY, That I attended deceased from ~~January~~ March, 1929, to June, 1929, that I last saw h.. alive on June 29 1929 and that death occurred, on the date stated above, at 8.30 A. m.

The CAUSE OF DEATH* was as follows:

Sarcoma of eye

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Sarcoma of Liver

(duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Yes Date of 1925 (see other side)

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) I. Frederick Lentz, M. D.

6 29, 1929 (Address) Temple Garden Apts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship Cem.	7/1/ 1929

20 UNDERTAKER Ward Sondheim ADDRESS 1830 Mt Royal Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

57

1—PLACE OF DEATH — ~~E 47273~~

REGISTERED NO. E 47273

CITY OF BALTIMORE: (No. 1129 W. North Ave ST., 19-54 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Nettie Kirsner

(a) RESIDENCE NO. 1129 W. North ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth 40 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Louis Kirsner

6 DATE OF BIRTH (month, day, and year): Aug —

7 AGE — Years: 55 — Months: — — Days: — — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Todres Levin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Minkow

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Louis Kirsner

(Address) 1129 W. North ave

15 Filed ... 19 ... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 29/29

17

I HEREBY CERTIFY, That I attended deceased from June-24, 1929 to June-29, 1929 that I last saw h[illegible] alive on June 29 1929 and that death occurred, on the date stated above, at 10 10 P m.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus

not known (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemmorrhage (duration) yrs mos. 6 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Herman Seidel, M. D.

6/30, 1929 (Address) 2404 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Southern Cem

DATE OF BURIAL: 6/30 19 29

20 UNDERTAKER: Jack Levin's

ADDRESS: 1434 E Balto St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47274 — E 47274

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE. (No. 1901 Linden Ave St. 4-20 WARD) — REGISTERED NO. 94-092

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Minnie Sterman

(a) RESIDENCE NO. 1901 Linden Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Isaac Sterman

6 DATE OF BIRTH (month, day, and year) Unk

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
51	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Israel Levy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Frank Greenberg

(Address) 2015 Callow Ave

15 Date JUN 30 1929, 19 H. C. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29/29

17 I HEREBY CERTIFY, That I attended deceased from June 24, 19 29, to June 29, 19 29

that I last saw h alive on June 29

and that death occurred, on the date stated above, at 10 30 P m.

The CAUSE OF DEATH* was as follows:

cerebral thrombosis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Hypertension

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Samuel Levithorne, M. D.

19 (Address) 1810 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Memorial	6/30/29

20 UNDERTAKER Jack Lauris ADDRESS 1439 Edmondson

Spec.—1-10-21—M&T—1500 Bks.

E 47275

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47275
REGISTERED NO.

1-PLACE OF DEATH Franklin Square Hospital 126

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

2-FULL NAME Mrs. Bessie Jessop

(a) RESIDENCE NO. 1429 W Fayette St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced (HUSBAND of or) WIFE of: James Jessop

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: 32 — Months — Days — If LESS than 1 day, hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Woodrow Wilson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Rachel Shipley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: C. M. Walz
(Address) Towanda Md

15 Filed 1 1929 C. HARRISON JONES, M. D. Registrar
Per ....

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 30 1929

17 I HEREBY CERTIFY, That I attended deceased from 6-22, 1929, to 6-30, 1929, that I last saw h alive on 6-30, 1929, and that death occurred, on the date stated above, at 2:30 P. m.

The CAUSE OF DEATH* was as follows:

General peritonitis, apparently primary, and Staphylococcic in nature

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 6-22-29

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) E. W. Hagle, M. D.

, 19 (Address) Franklin Square Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Brandenburg Md — DATE OF BURIAL: 7/3 1929

20 UNDERTAKER: William Cook — ADDRESS: 1217 St Paul

TION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47276

100-001

CERTIFICATE OF DEATH

E 47276

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 5609 Winner Ave WARD) 27-55

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth T. Miller

(a) RESIDENCE NO. 5609 Winner Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word):

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank W. Miller

6 DATE OF BIRTH (month, day, and year): Jan 28-1864

7 AGE — Years: 65 | Months: 5 | Days: 1 | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Magdeburg Germany

PARENTS

10 NAME OF FATHER: Henry Meisch

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Don't know

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Frank W. Miller Jr.

(Address): 5609 Winner Ave

15 Filed: 7-1-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 29-1929

17 I HEREBY CERTIFY, That I attended deceased from June 19, 1929, to June 29, 1929, that I last saw h alive on June 28, 1929 and that death occurred, on the date stated above, at 12:35 a m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary): Cardiac failure (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Blay O'Mc Cary, M. D.

6/29, 1929 (Address) 400 N Payson St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park

DATE OF BURIAL: July 1929

20 UNDERTAKER: Harry N Wilkes

ADDRESS: 5411 Belair Rd

Spec—12-23-21—E.B.R.S.—400 Eks.

47277

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 47277

1-PLACE OF DEATH

City of BALTIMORE: (No. 1607 (Bismarck) E. Kenwood ave St., 1-1 Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bartlomej Gawlik

(a) Residence No. 1007 E. Kenwood Ave St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 45 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX: male

4-COLOR OR RACE: White

5-Single, Married, Widowed, or Divorced. (Write the word.): widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of: widowed

6-DATE OF BIRTH (month, day and year): 1857

7-AGE: 72 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work: retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9-BIRTHPLACE (city or town) (State or Country): Poland

PARENTS.

10-NAME OF FATHER: dont know

11-BIRTHPLACE OF FATHER (city or town) (State or Country): Poland

12-MAIDEN NAME OF MOTHER: dont know

13-BIRTHPLACE OF MOTHER (city or town) (State or Country): Poland

14-

(Informant): Casimyr Gawlikz

(Address): East Hunsabarg Ave

15- Filed 1 - 1929 HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year): June 29/29

17- I HEREBY CERTIFY, That I attended deceased from Apr. 22 19 29 to June 29 19 29

that I last saw h alive on June 24 19 29

and that death occurred, on the date stated above, at 1030 m.

The CAUSE OF DEATH* was as follows:

Valvular Dis Heart

(Duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death? at home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

6/29/29 (Signed) [illegible] M. D.

(Address) 408 S Paca St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislaus Cem DATE OF BURIAL, July 1 1929

20-UNDERTAKER: Stephen J. Fialkowski ADDRESS 1800 E. Kenwood Ave

Spec.—1-12-23—M&T—500 Blks.

E 47278

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

58-002

E 47278
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 5224 Florence ave ST. 7-55 (WARD)

2-FULL NAME Elizabth Isabelle Penninger

(a) RESIDENCE NO. 5222 Florence Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: William A Penninger

6 DATE OF BIRTH (month, day, and year): May 4-1874

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min
55	1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Jesse A Hitchcock (JESSE)

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Sarah L Anderson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: William A Penninger

(Address): 5222 Florence Ave

15 Filed 1929 [illegible] HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 30 1929

17

I HEREBY CERTIFY, that I attended deceased from March 6th, 1928, to June 30, 1929, that I last saw h alive on June 29, 1929 and that death occurred, on the date stated above, at 9.50 P m.

The CAUSE OF DEATH* was as follows:

Splenic Anaemia

(duration) 1 yrs. 8 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Blood Examination

(Signed) E. E. Nichols, M. D.

(Address) Pikesville Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge Cem

DATE OF BURIAL: July 1 1929

UNDERTAKER: John O Mitchell Sons

ADDRESS: 1900 Eutaw

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47279 ✓ E 47279

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. 17-24 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Fannie Sampson

(a) RESIDENCE NO. 1235 Argyle Ave. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., If foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Leonis Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Thomas

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Records of

(Address) Baltimore City Hospitals

15 Filed JUL 1 1929, 19 S. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28th, 1929

17 I HEREBY CERTIFY, That I attended deceased from August 3, 1928, to June 28, 1929,

that I last saw her alive on June 28, 1929

and that death occurred, on the date stated above, at 5 P.M. m.

The CAUSE OF DEATH* was as follows:

Cause Unascertained

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes (duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) Thomas A. Hill M.D. Lane, M. D.

6-29, 19 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	July 1, 19 29
20 UNDERTAKER	ADDRESS
Franklin W Seitz	709 W 33 St.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47280

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47280

1—PLACE OF DEATH

REGISTERED NO. 84

CITY OF BALTIMORE: (No. 2122 N. Charles ST. 12-51 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth E. Willis

(a) RESIDENCE NO. 2122 N. Charles ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 82 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: John M. Willis

6 DATE OF BIRTH (month, day, and year): March 6, 1847

7 AGE — Years: 82 — Months: 5 — Days: 23 — If LESS than 1 day, hrs or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: James L. Dorsey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Sarah H. Richardson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Mrs. Mary V. Dorsey

(Address) 2122 N. Charles St

15 Filed JUL 1 - 1929

CHAMPION JONES, Registrar D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 29, 1929

17 I HEREBY CERTIFY, That I attended deceased from 5-1, 1929, to 6-29, 1929, that I last saw her alive on 6-28, 1929 and that death occurred, on the date stated above, at 7.50 A. m.

The CAUSE OF DEATH* was as follows:

ANGINA PECTORIS

(duration) — yrs. 2 mos. — ds.

CONTRIBUTORY (Secondary) CORONARY THROMBOSIS

(duration) — yrs. 1 mos. 20 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) John L. Dorsey, M. D.

, 19 (Address) 129 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Old Trinity, Dorchester Co. Md. — DATE OF BURIAL: July 1, 1929

20 UNDERTAKER: Chas. D. Mitchell & Sons — ADDRESS: 1900 Eutaw Place

Spec.—2-29-28—L. F. S.—500 Bks.

47281

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49

E 47281

1—PLACE OF DEATH University Hospital — REGISTERED NO. (If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Lombard & Green ST. 37-46 WARD)

2—FULL NAME Bertie M Haynes

(a) RESIDENCE NO. 2821 Rosalie ave ST., WARD 8a
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 21 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Richard C Haynes

6 DATE OF BIRTH (month, day, and year) Nov 29/1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
54		7	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Mathews Co Va.

PARENTS

10 NAME OF FATHER N. R Gray

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Octavia Billups

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Richard C Haynes
(Address) Soles P O Mathews Co Va

15 Filed C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30th 1929

17 I HEREBY CERTIFY, That I attended deceased from June 10th, 1929, to June 30th, 1929, that I last saw her alive on June 30th, 1929 and that death occurred, on the date stated above, at 8 45 A m.

The CAUSE OF DEATH* was as follows:

Cerebral tumor (Right side)

(duration) yrs. 8 mos. ds.

CONTRIBUTORY (Secondary) Hypostatic pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 6-18-29

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy - Operation

(Signed) McSmooth M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mathews Co Va	July 2 1929
20 UNDERTAKER Harry R. Annacost 4704	ADDRESS Edgewood Ave

Spec.—2-29-28—L. F. S.—500 Bks.

Cert 5-4 St Paul Ext Ad

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47282

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 437 So Bentalou ST. 20-69 WARD)

REGISTERED NO. 129 E 47282

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Susie C. Higinbotham

(a) RESIDENCE NO. 437 So Bentalou ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	W	Widow

a If married, widowed, or divorced HUSBAND of (or) WIFE of John B.

6 DATE OF BIRTH (month, day, and year) April 3/854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	2	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer) do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt-

PARENTS

10 NAME OF FATHER Chas W. Harvey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Hussey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Emilie Fowler

(Address) 437 So Bentalou St

15 Filed JUL 1 - 1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28 1929

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1924, to June 28, 1924, that I last saw her alive on June 27, 1924, and that death occurred, on the date stated above, at 11 a m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Wm Miller Cook, M. D.

6/29, 1929 (Address) 54 Stallion ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	July 1 1929

20 UNDERTAKER Wm Cook ADDRESS 217 St Paul St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47283

CERTIFICATE OF DEATH

100-001

REGISTERED E 47283

1-PLACE OF DEATH

City of Baltimore: (No. 1803 N. Patterson Pk Ave St., 8-16 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Melvin Robert Helm

(a) RESIDENCE NO. 1803 N. Patterson Pk Ave St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
m	W	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 20-29

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	X	5	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Snively A. Helm

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Waynesboro, P a

12 MAIDEN NAME OF MOTHER Lula A. Bristow

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Delta Grove, Va

14 Informant S.A. Helm (Father)
(Address) 1803 N. Patterson Pk

15 Filed JUL 1 1929 19... C. HAMILTON JONES, M. D.
Per ... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Probably Bronchopneumonia (Primary)

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) ... M. D.

6/29/29 (Address) 509 E. North Ave

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ave Baltimore Cemetery

DATE OF BURIAL 7/1 1929

20 UNDERTAKER Wellington Cook

ADDRESS 1172 Park Ave

Be sure that all blanks are properly filled. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47284

CERTIFICATE OF DEATH.

E 47284

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (a) Dreed Hell & Pork St. 17-52 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ellen C McAvoy

(a) RESIDENCE NO. 3715 Roland Ave. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James T. McAvoy

6 DATE OF BIRTH (month, day, and year) Feb. 6, 1881

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	48	4	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Dreeland

(State or country) Md.

PARENTS

10 NAME OF FATHER Peter F. Wilhelm

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Md.

12 MAIDEN NAME OF MOTHER Mary A. Morrow

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md.

14 Informant Lieut. Chas. E. Wilhelm

(Address) 2105 Smallwood St.

15 Filed 1929 E. HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-29 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gunshot Wound Through Head Suicide

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) [illegible] M. D.

(Coroner) 6/30, 1929 (Address) 3632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem July 1, 1929

20 UNDERTAKER Wm. J. Tuckner Sons ADDRESS N. Y. Ave & Pa

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47285

1929

E 47285

REGISTERED NO.

1-PLACE OF DEATH

City of Baltimore: (No. Hopkins Hospital St., 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Catherine Johnson

(a) RESIDENCE NO. 1133 McElderry St St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F	B	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown 1890

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	about 39			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) "
(State or country)

12 MAIDEN NAME OF MOTHER "

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) "

14 Informant Byron Wright
(Address) 1218 McElderry St

Filed [illegible] HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Intraventricular Hemorrhage

(Probably Homicide)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) [signature], M. D.

7/1/29 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lakewood County

DATE OF BURIAL 7/1 1929

20 UNDERTAKER Byron Wright

ADDRESS 1218 McElderry

COL-1 100 [illegible]

Be sure to print clearly, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47286

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

128 ✓ E 47286

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 24-33 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Mcquade

(a) RESIDENCE NO. 416 Grindall St. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., If foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Beulah

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tinner

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) ?
(State or country) Maryland

PARENTS

10 NAME OF FATHER John Mcquade

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary ~~Horner~~ Conner

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) Maryland

14 Informant Records of
(Address) Baltimore City Hospitals

15 Filed 1-1-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 31, 1929, to June 28, 1929, that I last saw him alive on June 28, 1929 and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Microbism, acute ? Coma

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Tubular Nephritis undetermined (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Pos. Gram Stain Urine Culture

(Signed) Warren H. McCann, M. D.

6-29, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	July 2 1929
UNDERTAKER Margaret J. Flynn	ADDRESS 411 Cathedral St.

Spec.—1-12-23—M&T—500 Bks.

E 47287

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 47287

100-01

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1130 N May ST.) 5-6 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.

2-FULL NAME Ida Lee Nellson

(a) RESIDENCE NO. 1130 N May ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 6 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colord	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 6 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		6	24	

8 OCCUPATION OF DECEASED Baby

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Samuel H Nellson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary Calvary

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Lillie Nellson

(Address) 1130 N May St

15 Filed 1-1929 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30 19 29

17 I HEREBY CERTIFY, That I attended deceased from June 25, 19 29, to June 30, 19 29,

that I last saw h alive on June 29, 19 29

and that death occurred, on the date stated above, at 1 m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs mos ds

CONTRIBUTORY (Secondary)

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) , M. D

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury cemetery

DATE OF BURIAL July 2 1929

20 UNDERTAKER Edward Bryson

ADDRESS 1691 Orleans St

TION is very important See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 47288

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

91-00 E 47288

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1200 Valley ST. 10-1 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Hugh Sharpe

(a) RESIDENCE NO. 1200 Valley ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73 -			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Cornelius Sharpe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ann Boyle

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Little Sisters of the Poor (Address) 2400 Gallow[illegible]

15 Filed 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 17, 1929, to June 30, 1929, that I last saw h[illegible] alive on June 24, 1929, and that death occurred, on the date stated above, at 3 p. m.

The CAUSE OF DEATH* was as follows:

Senility

Arteriosclerosis

Unknown (duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

7/1, 1929 (Address) 1216 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral

DATE OF BURIAL July 3 1929

20 UNDERTAKER Rita Weidefeld

ADDRESS 91 E Fremont Ave

Spec.—1-10-21—M&T—1500 Blks.

E 47289 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 161-001

CERTIFICATE OF DEATH.

E 47289 REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH Franklin Square Hospital

CITY OF BALTIMORE: (No. ..... ST. 14-27 WARD)

2-FULL NAME Baby Girl Keever

(a) RESIDENCE NO. 128 N. Calhoun ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	White	Infant

5a If married, widowed, or divorced HUSBAND of or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) June 29. 1929

7 AGE	Years	Months	Days	If LESS than 1 day, 7 hrs or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work .....

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Franklin Square Hospital

PARENTS

10 NAME OF FATHER Lynn Kyle Keever

11 BIRTHPLACE OF FATHER (city or town) (State or country) North Carolina

12 MAIDEN NAME OF MOTHER York

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Mother (Address) .....

15 Filed JUL - 1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29 1929

17 I HEREBY CERTIFY, That I attended deceased from June 29 . 1929 . to June 29 . 1929. that I last saw h alive on June 29 . 1929, and that death occurred, on the date stated above, at 8:15 a. m.

The CAUSE OF DEATH* was as follows:

Prematurity
Miscarriage (7 months)

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Clinical

(Signed) Arthur Rathmann, M. D.

6/29/1929 (Address) Franklin Sq. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL: 19

20 UNDERTAKER ..... ADDRESS ..... JUL 1 1929

Commissioner of Health.

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47290

CERTIFICATE OF DEATH

E 47290

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 536 N Lakewood Ave WARD 10)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Camillo Incrocci

(a) RESIDENCE NO. 536 N. Lakewood Ave WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Antonitta Incrocci

6 DATE OF BIRTH (month, day, and year) Sept 26, 1863

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
65	9	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) Tailor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Cesar

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Alfred Intatucci

(Address) 536 N. Lakewood ave

15 Filed ..., 19... C. HAMILTON JONES, M. D. Registrar

1 - 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29 29

17

I HEREBY CERTIFY, That I attended deceased from May 13, 1929, to June 29, 1929, that I last saw h... alive on June 29, 1929 and that death occurred, on the date stated above, at 11 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of May 29 29

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Philibert Artigues, M. D.

, 19 (Address) 2942 E. Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	July 3 1929
20 UNDERTAKER	ADDRESS
Frank V. Pikitone	2816 E. Baltimore st

Spec.—1-10-21—M&T—1500 Bks.

E 47291 418 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 1929 E 47291

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 6-10 WARD)

2-FULL NAME Mary Agnino

(a) RESIDENCE NO. 2611 E Fayette ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W.

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dominico

6 DATE OF BIRTH (month, day, and year) 7/12/90

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
38	11	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER John Massino

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 1-1929, 19 C. HAMBLETON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29 1929

17

I HEREBY CERTIFY, That I attended deceased from May 17, 1929, to June 29, 1929, that I last saw her alive on June 29, 1929, and that death occurred, on the date stated above, at 7.50 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Anaemia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory.

(Signed) Charles M. Mc Lure, M. D.

6/29, 1929 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer DATE OF BURIAL July 3 1929

20 UNDERTAKER Frank V. Pikitone ADDRESS 2815 E. Balto St

TION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

É 47292 HEALTH DEPARTMENT—CITY OF BALTIMORE É 47292

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Sinai Hospital REGISTERED NO. 57

CITY OF BALTIMORE: (No. 20-69 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma M Rhodes

(a) RESIDENCE No. 31. N Catherine St WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 15=1862

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
67	2	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Conrad Hauber

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary Custer

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs McGonigal (Address) 31. N Catherine St

15 Filed: 1929 C. HAMPSON JONES, M. D. Registrar

By: [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29 1929

17 I HEREBY CERTIFY, That I attended deceased from June 24, 1929, to June 29, 1929, that I last saw h alive on June 29, 1929, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Cellulitis of Face,

CONTRIBUTORY (Secondary) (duration) yrs. mos. 5 ds. Mitral Stenosis (duration) 1 yrs. mos. ds. Diabetes Mellitus

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) [illegible] M. D.

, 19 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross DATE OF BURIAL July 2 1929

20 UNDERTAKER: Trinity Cem ADDRESS 1258 Hoff

TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47293

CERTIFICATE OF DEATH

E 47293
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 6704 Railway ave Sub-Station 26-37 Ward)

2-FULL NAME Henry Wernsing

(a) RESIDENCE NO. 6704 Railway Ave, Ward
(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Wernsing

6 DATE OF BIRTH (month, day, and year) January 24 1891

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	38	5	6	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Steel jacker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) New Jersey

PARENTS

10 NAME OF FATHER Geo. Wernsing

11 BIRTHPLACE OF FATHER (city or town)
(State or country) New Jersey

12 MAIDEN NAME OF MOTHER Wilhelmina Hoecks

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Anna Wernsing
(Address) 6704 Railway Ave

15 Filed ... C. HAMPTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

about (duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Stenosis

few minutes (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? At place & Wall

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) James M Hinton M. D.

6/30 1929 (Address) 700 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cemetery — DATE OF BURIAL July 3 1929

20 UNDERTAKER George W. Zirkler — ADDRESS 737 E. Eager St

IMPORTANT. See instructions on back of certificate. OF DEATH in plain terms, so that it may be properly classified. Last statement of OCCUPATION is very

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47294

CERTIFICATE OF DEATH

E 47294

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Stmr. City of Baltimore

City of Baltimore: (No. En route Norfolk Va. to Baltimore, Md. Ward)

2-FULL NAME Alberta Bowman Luther.

(a) RESIDENCE NO. 2288 Hyde St. San Francisco, California.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, (or) WIFE of Arthur P. Luther.

6 DATE OF BIRTH (month, day, and year) April 23, 1863

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	66	2	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Mass.
(State or country)

PARENTS

10 NAME OF FATHER Do not know

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Arthur P. Luther. (husband)
(Address) 2238 Hyde St. San Francisco, Cal.

15 Filed JUL 1 - 1929 19 G. HAMPTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 26, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry & autopsy (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said autopsy and inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:

Coronary disease of the Heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy & inquiry

(Signed) Otto A. Reinhard, M. D.

7/1, 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem.

DATE OF BURIAL July 1 1929

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47295

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 47295

1—PLACE OF DEATH

REGISTERED NO. 25-71

CITY OF BALTIMORE: (No. 210 S. Tremont Road ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lillie Rude Dill

(a) RESIDENCE NO. 210 S. Tremont Road ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 21, 1890

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	39	2	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Saleslady

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Joel Gutman & Co.

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER John Dill

11 BIRTHPLACE OF FATHER (city or town) Washington
(State or country) D. C.

12 MAIDEN NAME OF MOTHER Irene Jane Forrest

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Mr. John Dill
(Address) 210 S. Tremont Road

15 Filed JUL 1 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29, 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 19, 1929, to June 29, 1929.

that I last saw her alive on June 29, 1929

and that death occurred, on the date stated above, at 1.30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac decompensation

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? Same

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Cl & Phy exam

(Signed) Fredk T. Kuyper, M. D.

7/1, 1929 (Address) 3321 Frederick Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL July 2 1929

20 UNDERTAKER Joseph B Cook

ADDRESS 1003 West Baltimore St.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47296

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

179 E 47296

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 12 North Calhoun ST., 14-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Frances Newton

(a) RESIDENCE NO. 12 North Calhoun ST., WARD

(Usual place of abode) 65

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of L. Howard Newton

6 DATE OF BIRTH (month, day, and year) March, 10th. 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	3	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Washington (State or country) D. C.

PARENTS

10 NAME OF FATHER Nelson R. Peregoy

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ann Elizabeth Stahl

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Verna C. Newton

(Address) 12 N. Calhoun St.

15 Filed 1-1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June, 29th. 1929

17 I HEREBY CERTIFY, That I attended deceased from May 17, 1926, to June 29th, 1929, that I last saw h alive on June 29, 1929, and that death occurred, on the date stated above, at 4.25 P. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility Pernicious Anaemia

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Bernard S. Francis, M. D.

6/29, 1929 (Address) 1707 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL July 2nd 1929

20 UNDERTAKER Joseph D. Cook

ADDRESS 1002 N. Eutaw St.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47297

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47297

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE. (No.) 1627 Laurens ST. (WARD) 16-27

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie Thomas

(a) RESIDENCE NO. 1627 Laurens ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of Alonzo Thomas

6 DATE OF BIRTH (month, day, and year) May 5-1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	1	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER J. Hitchcock

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penn. Know

12 MAIDEN NAME OF MOTHER Mary Purdum

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ohio

14 Informant Mrs Daisy Hamilton

(Address) 1627 Laurens St

15 Filed JUL - 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29-29

17 I HEREBY CERTIFY That I attended deceased from May 12, 1929 to June 29, 1929 that I last saw h alive on June 27, 1929 and that death occurred, on the date stated above, at 2.1= m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pylorus

(duration) yrs. 2 mos. + ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Place of death

Did an operation precede death? No Date of

Was there an autopsy? Family refused

What test confirmed diagnosis? Clinical Symptoms

(Signed) Charles E. Clark, M. D.

(Address) 3214 Piedmont Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	7/2 1929
20 UNDERTAKER William Cook	ADDRESS 1217 St Paul

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47298

CERTIFICATE OF DEATH

31 E 47298

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2217 Newkirk ST. 7-6-36 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Paul B. Schell

(a) RESIDENCE NO. 2217 Newkirk ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Florence C. Schell

6 DATE OF BIRTH (month, day, and year) Aug 27 1905

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23	10	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Inspector

(b) General nature of industry, business, or establishment in which employed (or employer) Caspher Works

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER B. F. Schell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Stella Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant B. F. Schell

(Address) 2217 Newkirk

15 Filed 7-1-1929 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30 1929

17 I HEREBY CERTIFY, That I attended deceased from June 26, 1929, to June 30, 1929, that I last saw h.im alive on June 29, 1929, and that death occurred, on the date stated above, at 8:00 A m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of Lungs

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted If not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Observation

(Signed) Horace B. Tel M. D.

7/1, 1929 (Address) 515 N. Highlandtown

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Mary's Cemetery Hayden — DATE OF BURIAL 7/3 1929

20 UNDERTAKER Williams Cook — ADDRESS 1217 St Paul

Spec.—2-29-28—L. F. S.—500 Bks.

E 47299

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47299

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH Balto City Hosp

CITY OF BALTIMORE: (No. Balto St. 7-6-37 WARD)

2—FULL NAME Martin Rozinski

(a) RESIDENCE NO: Unknown ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Germany
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Balto City Hosp
(Address)

15 6-29-1929 E. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-30-29

17 I HEREBY CERTIFY, That I attended deceased from 1-23-, 19 29 to 6-30-, 19 29

that I last saw him alive on 6-29, 19 29

and that death occurred, on the date stated above, at 7-30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

Myocardial Failure

(duration) 1 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Senile Psychosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Harry Goldsmith, M. D.

6-30, 19 29 (Address) Balto City Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

Commissioner of Health

JUL 1 - 1929

Spec.—2-29-28—L. F. S.—500 Bks.

E 47300

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 47300

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alexander Bailey

(a) RESIDENCE NO. 114 N. Collington ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., If foreign birth? —yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER William Bailey

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Lena Bailey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) BALTIMORE CITY HOSPITALS

15 Filed 7-1-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-28-29

17 I HEREBY CERTIFY, That I attended deceased from March 2, 1929, to 6-28-29, that I last saw him alive on 6-28, 1929 and that death occurred, on the date stated above, at 6:50 A m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis: Hypertension

(duration) 8 yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Marion A. McKean, M. D.

6-28, 1929 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cem Baltimore Md. DATE OF BURIAL 7/2/29

UNDERTAKER Dylan Wright ADDRESS 1218 N. Eden St.

Commissioner of Health JUL 1 - 1929

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47301 E 47301

CERTIFICATE OF DEATH

49

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Baltimore City Hosp. ST. 4-6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Wm. Williams

(a) RESIDENCE NO. 48 Market Place ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of indostry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ga.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Record

(Address)

15 Filed JUL 1 1929, 19 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/27/29

17 I HEREBY CERTIFY, That I attended deceased from 6/5, 1929, to 6/27, 1929

that I last saw h.. alive on 6/27, 1929

and that death occurred, on the date stated above, at 8 30 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Prostate Gland

(duration) Unknown ds.

CONTRIBUTORY (Secondary) Secondary anemia

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. U. Lumpkin, M. D.

6/29, 1929 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

JUL 1 - 1929

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47302 31 **E 47302**

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 211 S. Chapel (ST.) 2-4 (WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emma E. Lang

(a) RESIDENCE NO. 211 S. Chapel St. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: W.

5 Single, Married, Widowed, Divorced, (write the word): Married

5a If married, widowed or divorced (or) WIFE of: Joseph L. Lang

6 DATE OF BIRTH (month, day, and year): Jan 6 1879

7 AGE — Years: 50 — Months: 6 — Days: 24 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Washington D.C.

PARENTS

10 NAME OF FATHER: L. Seipel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Joseph L. Lang (Address) 211 S. Chapel St.

15 Filed: 1-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 30/29

17 I HEREBY CERTIFY, That I attended deceased from March 1, 1929, to June 30, 1929, that I last saw her alive on June 30, 1929 and that death occurred, on the date stated above, at 12.50 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

Diabetes mellitus,

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Dr. Cirilo Bertagnini, M. D.

, 19 (Address) 211 S. Chapel

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: July 3rd 1929

20 UNDERTAKER: Martin W. Deffel Inc. — ADDRESS: 37 Conn Ave

Cor.—10-10-29—A Co.—100 Bks.

Anton Chlan

E 47303

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

167-00[illegible]

E 47303

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2531 E. Hoffman St. 8-16 Ward)

2-FULL NAME Anton Chlan

(a) RESIDENCE NO. 2531 E. Hoffman St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Anna Chlan

6 DATE OF BIRTH (month, day, and year) Aug 14/1855

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	73	10	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired Shoemaker
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Austria

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant wife
(Address) 2531 E. Hoffman St.

15 Filed [illegible] 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Illuminating Gas Asphixiation

Suicide

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature] M. D.

7/1/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer

DATE OF BURIAL July 2nd 1929

20 UNDERTAKER Leo J. Leook

ADDRESS 1723 Patterson Ave

IMPORTANT—Fill in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47304

CERTIFICATE OF DEATH

118-002

E 47304

REGISTERED NO. 13-57

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1319 (ST.) Eldon Ave (WARD) 13

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry D. Robey

(a) RESIDENCE NO. 1319 (ST.) Eldon Ave (WARD) 13

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Dora L. Robey

6 DATE OF BIRTH (month, day, and year): Nov. 13, 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	7	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Retired 10 years

9 BIRTHPLACE (city or town) (State or country): London Co. Va

PARENTS

10 NAME OF FATHER: Rev. Andrew J. Robey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Martha E. Strother

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Mrs. Dora L. Robey

(Address) 1319 Eldon Ave.

15 Filed 1-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 30-1929.

17 I HEREBY CERTIFY, That I attended deceased from June 27, 1929. to June 30, 1929.

that I last saw h[illegible] alive on June 30, 1929

and that death occurred, on the date stated above, at 2[10] A. m.

The CAUSE OF DEATH* was as follows:

Acute Pulmonary Edema

(duration) yrs. mos. ½ ds.

CONTRIBUTORY (Secondary) Acute Intestinal Obstruction

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs + Symptoms

(Signed) Frank H. Martin, M. D.

, 19 (Address) 4037 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	July 2, 1929.

20 UNDERTAKER: Horace M. Rodgers

ADDRESS: 631 Falls Road

Spec.—1-10-21—M&T—1500 Bks.

(Font Ave)

E 47305

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

92 47305

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 807 E. Fairmount, ST. 24-34 WARD

2-FULL NAME Catherine A. Lemerick

(a) RESIDENCE NO. 807 E. Fairmount ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 48 yrs. 11 mos. 26 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Robert Lemerick

6 DATE OF BIRTH (month, day, and year): July 6, 1880

7 AGE: Years 48 Months 11 Days 25

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): "

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Robert Fegler

11 BIRTHPLACE OF FATHER (city or town) (State or country): [illegible]

12 MAIDEN NAME OF MOTHER: Shuckle

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore

14 Informant (Address): Robert Lemerick, 807 E. Fairmount

15 [illegible] 1929

C. HAMPSON JONES, M. D. Registrar

Per [illegible]

TION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 30 1929

17

I HEREBY CERTIFY, That I attended deceased from June 27, 1929, to June 30, 1929,

that I last saw her alive on June 28, 1929,

and that death occurred, on the date stated above, at 11 45 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis.

" Endocarditis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Anemia & Rheumatism.

Carcinoma yrs. mos. ds.

18 Where was disease contracted if not at place of death? in Pa.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Evidence

(Signed) O. Hann, M. D.

, 19 (Address) 1715 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Olivet Cem. DATE OF BURIAL: July 3, 1929

20 UNDERTAKER: A. Howard Ewins ADDRESS: 38 E. Fairmount

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47306

REGISTERED NO. **E 47306**

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH **St.Regis Hotel.**

City of Baltimore: (No. **1817 N.Charles St.** St. **12-19** Ward)

2-FULL NAME **Roger Warfield Perrin.**

(a) RESIDENCE NO. **St.Regis Hotel.** **1817 N.Charles St.** St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. **14** ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married.

5a If married, HUSBAND of [illegible] **Adele W.Perrin.**

6 DATE OF BIRTH (month, day, and year) **February 24,1889**

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	40	4	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work **Stock salesman.**
(b) General nature of industry, business, or establishment in which employed (or employer) **Stocks & Bonds.**
(c) Name of employer **Self.**

9 BIRTHPLACE (city or town) **River Falls, Misc.**
(State or country)

PARENTS

10 NAME OF FATHER **Frank L.Perrin.**

11 BIRTHPLACE OF FATHER (city or town)
(State or country) **Kinnikinnic Misc.**

12 MAIDEN NAME OF MOTHER **Fannie Ball.**

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) **Wheeling, W.Va.**

14 Informant **E.J.Shackelford.(friend)**
(Address) **12 Stock Exchange, City.**

Filed **L 2 - 1929** **C. HAMPSON JONES, M. D.** Registrar

Per [illegible]

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) **July 1, 1929** 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an **inquiry** (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said **inquiry** (Inquest, autopsy or inquiry) find that said deceased came to **his** death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.
Acute dilatation of the Heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? **No.** Date of

Was there an autopsy? **No.**

What test confirmed diagnosis? **Inquiry**

(Signed) **Otto M. Reinhardt** M. D.

7/1 . 1929 (Address) **1017 N. Charles St.**

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New York City, N.Y.	July 3 1929

20 UNDERTAKER **HART & MOWEN COMPANY**
WILLIAM F. WOOSEN, Successor

ADDRESS **108 W. NORTH AVE.**

IMPORTANT.—Physicians are requested to make this certificate as complete as possible. Every item should be answered in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47307

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-001

CERTIFICATE OF DEATH

E 47307

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 390 Foster ave ST., 16-37 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Infant Lawrence

(a) RESIDENCE NO. 390 Foster ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 1 - 1929

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	—	—	—	45 min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER George Lawrence

11 BIRTHPLACE OF FATHER (city or town) (State or country) Penna

12 MAIDEN NAME OF MOTHER Mildred W. McCabe

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant George Lawrence

(Address) 390 Foster ave

15 Filed 7-2-1929 HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/1/29.

17 I HEREBY CERTIFY, That I attended deceased from 7/1/29, 19..., to 7/1/29, 19..., that I last saw h— alive on 7/1/29, 19..., and that death occurred, on the date stated above, at 945 a m.

The CAUSE OF DEATH* was as follows:

Premature Labor.

(duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) 6½ months fortus

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Wm. E. Garrell M. D.

7/1, 1929 (Address) 633 S. Conkling

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Trinity Cemetery	July 2 1929
20 UNDERTAKER	ADDRESS
George W. Zirkin	1737 East

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47308

1-PLACE OF DEATH

CERTIFICATE OF DEATH

90

E 47308

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of Baltimore: (No. 3427 Piedmont St. 15-61 Ward)

2-FULL NAME Thos. F. Fitzberger

(a) RESIDENCE NO. 3427 Piedmont St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 75 yrs. 10 mos. 21 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Theresa.

6 DATE OF BIRTH (month, day, and year) Aug 11-1853

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	75	10	21	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Henry Fitzberger

11 BIRTHPLACE OF FATHER (city or town) Germany
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Germany
(State or country)

14 Informant Theresa Fitzberger
(Address) 3427 Piedmont St.

15 Filed 7-2-1929 19 C. HAMILTON JONES, M. D. Registrar
By [illegible]

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) July 1st 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) J. T. Costik, M. D.

(Address) Coroner.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	July 3 1929

20 UNDERTAKER Chas. G. Black ADDRESS 742 W. Northern

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47309

43 647309

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Baltimore City Hosp, ST., 14-27 (WARD)

2—FULL NAME Joshua Freeland

(a) RESIDENCE NO. 1418 W. Mulberry ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	~~Unknown~~ Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Matilda Freeland

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Wm. Freeland

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Eliz. Booz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Record

(Address)

15 Filed 7-2, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1, 1929

17 I HEREBY CERTIFY, That I attended deceased from 6/18, 1929, to 7/1, 1929, that I last saw h[illegible] alive on 7/1, 1929, and that death occurred, on the date stated above, at 7 P.M.

The CAUSE OF DEATH*, was as follows:

Carcinoma floor of mouth.

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Secondary Anemia

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. H. Plumpton, M. D.

7/1, 1929 (Address) Balt. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. Mt. Lebanon Cemetery

DATE OF BURIAL July 4, 1929

20 UNDERTAKER Mrs. Katie R. Williams

ADDRESS 322 N. Schroeder St

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47310

CERTIFICATE OF DEATH.

E 47310
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 918 (ST.) Shields (WARD) 17-24-29

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Newton

(a) RESIDENCE NO. 918 (ST.) Shields (WARD)
(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 COLOR OR RACE: Col
5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary Newton

6 DATE OF BIRTH (month, day, and year): 1864

7 AGE: Years 65 | Months | Days | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant: Verline Newton
(Address) 918 Shields St.

15 Filed 2-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 30 1929

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1929, to June 30, 1929, that I last saw him alive on June 29, 1929, and that death occurred, on the date stated above, at 12:30 a m

The CAUSE OF DEATH* was as follows:

Endocarditis + nephritis

(duration) 2 yrs. mos ds.

CONTRIBUTORY
(Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) H. Casey, M. D.

, 19 (Address) Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Williams Cem. DATE OF BURIAL: 6-2 1929

20 UNDERTAKER: Daniel Fenton ADDRESS 916 Dame.

FRONT—Very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47311

CERTIFICATE OF DEATH

E 47311

1—PLACE OF DEATH

CITY OF BALTIMORE (No.) 4015 Hayward Av. (St., Ave., Rd., etc.) WARD 57

2—FULL NAME Samuel S. McCauley

(a) RESIDENCE NO. 4015 Hayward ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

58-00 Alkhurst 4012 Park Heights

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of: Elizabeth

6 DATE OF BIRTH (month, day, and year): Nov 21 1858

7 AGE: Years 70; Months 7; Days 9; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Contractor

(b) General nature of industry, business, or establishment in which employed (or employer): Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: John McCauley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Mary Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Elizabeth McCauley

(Address) 4015 Hayward

15 Filed JUL 2 - 1929

SAMUEL B. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 30 29

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1929 to June 30, 1929

that I last saw him alive on , 19

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Pernicious Anaemia

Gen. arterio-Sclerosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile pyorrhea alv.

(duration) mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) James S. Ashehurst M. D.

(Address) 4012 Park Heights ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet

DATE OF BURIAL: 7/2 1929

20 UNDERTAKER: William Cook

ADDRESS: 127 S Paul

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47312

CERTIFICATE OF DEATH

51 ✓ E 47312

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 636 ½ Chester ST., 7-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna Hayman

(a) RESIDENCE NO. 836 N. Chester ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widower

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph W. Hayman

6 DATE OF BIRTH (month, day, and year) Not known

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER South Dean

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Anna Hayman

(Address) 836 N Chester St

15 Filed JUL 2 1929 19 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29 29

17 I HEREBY CERTIFY, That I attended deceased from July 1 1928 to June 29 1929

that I last saw her alive on June 29 1929

and that death occurred, on the date stated above, at 3 P. m.

The CAUSE OF DEATH* was as follows:

Diabetic Coma

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Ralph Wilbur Reamer M. D.

(Address) 836 N Chester St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Ly Redeemer	July 3 1929

20 UNDERTAKER Ford Bradshaw ADDRESS 1106 Druid

Spec.—2-29-28—L. F. S.—500 Bks.

E 47313 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001

E 47313

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 802 W. Lorologa ST., 18-26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alice T. Coale,

(a) RESIDENCE NO. 802 W Lorologa ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 78 yrs. 8 mos. 24 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Wm. A. Coale

6 DATE OF BIRTH (month, day, and year) Oct 6th 1850

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
78	8	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: /

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER James. Towe

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER Ellen. Bowen

13 BIRTHPLACE OF MOTHER, (city or town) (State or country): Md.

14 Informant: Mrs. Mary J. Hoskins

(Address) 1816 W Lafayette St.

15 Filed 2 1929 HAMILTON JONES Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30th 1929.

17 I HEREBY CERTIFY, That I attended deceased from June 23, 1929 to June 30, 1929.

that I last saw her alive on June 30 1929

and that death occurred, on the date stated above, at 10:45 A. m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

CONTRIBUTORY (Secondary) Pulmonary Edema (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? (duration) yrs. mos. 1 ds.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry Coleman, M. D.

19 29 (Address) 628 Mulberry Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cem. DATE OF BURIAL July 3rd 1929.

20 UNDERTAKER John Cowen & Son. ADDRESS 701 Belmont

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47314 — CERTIFICATE OF DEATH — E 47314

1—PLACE OF DEATH Union Memorial Hospital — REGISTERED NO. 12-49

CITY OF BALTIMORE: (No. ..... ST. ..... WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James K P Shoemaker

(a) RESIDENCE NO. Homestead Pa ST., ... WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ..... yrs. mos. 26 ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Eliz Carns

6 DATE OF BIRTH (month, day, and year) Oct 14, 1845

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	83	7	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Real Estate Bus (Retired)

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Levi Shoemaker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Anna Fair

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Deceased

(Address)

15 Filed 2-1929 C. H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 6, 1929, to July 2, 1929, that I last saw h[im] alive on July 2, 1929, and that death occurred, on the date stated above, at 4:25 A.m.

The CAUSE OF DEATH* was as follows:

Benign Prostatic Hypertrophy with Cardiac Hypertrophy and hypertension, and renal insufficiency (duration) 3 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Uraemia (duration) — yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Blood Chemistry Exam

(Signed) Samuel McGranahan, M. D.

July 2, 1929 (Address) Union Mem Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Homestead Pa.	July 5 1929.
20 UNDERTAKER Stewart Mortuary	ADDRESS Paul's

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

47315

CERTIFICATE OF DEATH.

E 47315

REGISTERED NO._____

1-PLACE OF DEATH

City of BALTIMORE: (No. 2803 Hilldale St., 15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry H. Driscoll Jr

(a) RESIDENCE NO. 2803 Hilldale St. Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Grace E. Driscoll

6 DATE OF BIRTH (month, day, and year):

7 AGE: Years: 42. Months: Days: IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, professinn or particular kind of work: Clothing Designer

(b) General nature of industry, business, or establishment in which employed (or employer): Jacob Hess Co

(c) Name of employer

9 BIRTHPLACE (city or town): Mass.

(State or country)

PARENTS

10 NAME OF FATHER: H. H. Driscoll

11 BIRTHPLACE OF FATHER (city or town): Mass.

(State or country)

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Mass.

14 Informant: Grace E. Driscoll

(Address): 2803 Hilldale St

15 Filed ..... 19.....

C. HARRISON JONES, M. D.

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/30 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest

(Inquest, autopsy or inquiry)

thereon and from the evidence obtained by said Inquest

(Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Valvular Disease of Heart

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) [illegible] M. D.

(Coroner)

(Address) 7632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Springfield Mass. Date of Burial 7/3/1929

20 UNDERTAKER: H C Brauning Son ADDRESS 1136 Eastern Ave

very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47316

CERTIFICATE OF DEATH

167-001

E 47316
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
City of Baltimore: (No. W Balto Gen Hosp St., 20-69 Ward)

2-FULL NAME Lillian P Wheatley

(a) RESIDENCE NO. 2642 Lauretta St., Ward
(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. 1 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 Color or Race: White
5 Single, Married, Widowed or Divorced. (write the word): married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of: Jackson D. Wheatley

6 DATE OF BIRTH (month, day, and year): May 21-1902

7 AGE: Years 27 | Months 1 | Days 8 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town): Balto
(State or country): Md

PARENTS

10 NAME OF FATHER: Wm Ruhl
11 BIRTHPLACE OF FATHER (city or town): Md
(State or country)
12 MAIDEN NAME OF MOTHER: Lula A. Hann
13 BIRTHPLACE OF MOTHER (city or town): Md
(State or country)

14 Informant: Lula A. Ruhl
(Address): 2643 Lauretta

Filed 6-2-1929 1929 C. HAMILTON JONES, M. D. Registrar
By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 29th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to h death on the day stated above.

The CAUSE OF DEATH* was as follows:
(Suicide)
Asphyxia.
Gas from Kitchen Range
(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)
(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? 2642 Lauretta St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.
(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

15 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park
DATE OF BURIAL: 19

20 UNDERTAKER: Geo W Little
ADDRESS:

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47317

CERTIFICATE OF DEATH

E 47317
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
City of Baltimore: (No. W. Balto Gen Hosp Ward) 20-69 19

2-FULL NAME Wm M. Thomas

(a) RESIDENCE NO. 2643 Edmondson St., Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male
4 Color or Race: White
5 Single, Married, Widowed or Divorced, (write the word): Widower

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 18 1877

7 AGE: Years 56 | Months 10 | Days 12 | IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Electrician
(b) General nature of industry, business, or establishment in which employed (or employer): 029
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Virginia

PARENTS

10 NAME OF FATHER Elias W. Thomas

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Eliza Bell

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia

14 Informant: Wm M Thomas Jr
(Address) Charlotte & Pratt

15 Filed ... 19 ... C. HARRISON JONES, M. D. Registrar

L 2 - 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

(a) Accidental
2nd degree burns
Brain, Chest & Head
(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) Explosion of Gas
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? 2642 Lorraine Ave
Did an operation precede death? No Date of
Was there an autopsy? No
What test confirmed diagnosis? Regular
(Signed) A. Bellenth M. D.
(Address) 30 W Pratt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park
DATE OF BURIAL 19

20 UNDERTAKER: Geo W Little
ADDRESS

IMPORTANT. See instructions on back of certificate. If DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very

Spec.—1-12-23—M&T—500 Blks.

E 47318

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49

E 47318

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 912 Hollins ST. 18-29 WARD)

2-FULL NAME James Depue

(a) RESIDENCE NO. 912 Hollins ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 5, 1871

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
58	1	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bricklayer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Philadelphia Pa

PARENTS

10 NAME OF FATHER John Depue

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Caroline Slife

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Emma Depue

(Address) 912 Hollins St

15 2 Filed 1929 C. HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/30 1929.

17 I HEREBY CERTIFY, That I attended deceased from 6/25, 1929. to 6/30, 1929. that I last saw h alive on 6/30/29. 19 and that death occurred, on the date stated above, at 1 A. m.

The CAUSE OF DEATH* was as follows:

Metastatic Carcinoma Rec

known

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Bernard Fenny, M. D.

6/30/1929 (Address) 710 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL July 2 1929

20 UNDERTAKER Charles H Keehner — ADDRESS 153 Hollins

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47319

11-002

CERTIFICATE OF DEATH

E 47319

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 212 E Fayette ST. 72-30 WARD)

2—FULL NAME Margaret Bisesi

(a) RESIDENCE NO. 608 S Paca ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 5, 1889

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	40	5	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Alex McIntosh

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country)

12 MAIDEN NAME OF MOTHER Maria Elliott

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country)

14 Informant Frank Bisesi

(Address) 608 S Paca

Filed JUL 2 - 1929, 19 HARRISON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/30/29

17 I HEREBY CERTIFY, That I attended deceased from 6-18, 19 29 to 6/30/29, 19 29, that I last saw h[illegible] alive on 6/30/29, 19 29 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis

(duration) yrs. 1 mos. 12 ds.

CONTRIBUTORY (Secondary) Acute Cystitis

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical sign's

(Signed) C J Carpenter M. D.

7-2, 19 29 (Address) 320 N Carey St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	July 3 1929
20 UNDERTAKER	ADDRESS
Charles H Kramer	Hollins

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47320

CERTIFICATE OF DEATH

44 ✓

E 47320

1—PLACE OF DEATH

REGISTERED NO. 13-59

CITY OF BALTIMORE: (No. 2420 Callow Ave. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Albert E. Lissberger

(a) RESIDENCE NO. 2420 Callow ST. Ave. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2½ yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	M

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Minnie W. Lissberger

6 DATE OF BIRTH (month, day, and year) Aug. 14, 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	53	10	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bot

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Chicago Ill.
(State or country)

PARENTS

10 NAME OF FATHER David Lissberger

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Caroline Hess

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant M. al Lissberger Jr.
(Address) 2420 Callow Ave.

15 Filed ....., 19.... Registrar

C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/1/29

17 I HEREBY CERTIFY, That I attended deceased from April 1, 1929, to July 1, 1929.

that I last saw h[illegible] alive on July 1 1929

and that death occurred, on the date stated above, at 11 45 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. [illegible] mos. ds.

18 Where was disease contracted if not at place of death? [illegible] ✓

Did an operation precede death? Yes Date of June 6-29

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Frederick Lantz, M. D.

7/1, 1929 (Address) Temple Garden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ohab S Shalom

DATE OF BURIAL 7/3 1929

20 UNDERTAKER David Sondheim

ADDRESS 118-120 W Mt. Royal Ave.

7-2-1929 P.M.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47321 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47321

CERTIFICATE OF DEATH

74-001

1—PLACE OF DEATH 105 Ridgewood Road REGISTERED NO. 27-53

CITY OF BALTIMORE: (No. Roland Park ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Etta G. Levy

(a) RESIDENCE NO. 105 Ridgewood ST. Roland Park WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Julius Levy 1867

6 DATE OF BIRTH (month, day, and year) Nov 29, 1867

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	7	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Frederick Guggenheimer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Carrie Hamburger

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Miss J. Guggenheimer (Address) 101 Ridgewood Rd.

15 Filed JUL 2 1929 HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 27, 1929, to July 2, 1929, that I last saw h dr alive on July 1, 1929 and that death occurred, on the date stated above, at 5:45 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral hemmorhage

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Arterial hypertension

(duration) 12 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical diagnosis & symptoms

(Signed) Charles R. Austrian, M. D.

. 19 (Address) 1417 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Balto. Hebrew Cem.	7/4 1929

20 UNDERTAKER David Sondheim ADDRESS 1520 W Baltimore

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47322 E 47322

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Little Sisters of the Poor ST. 10-14 WARD)

REGISTERED NO. 91

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Lange

(a) RESIDENCE NO. 1206 Valley ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mr. G. Lange

6 DATE OF BIRTH (month, day, and year): Dec 2 1845

7 AGE — Years: 83 Months: 6 Days: 29 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Bernard Lisk

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: Mary Lisk

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14

Informant: Little Sisters of the Poor

(Address): 1206 Valley St.

Filed JUL 2 - 1929

C. HAMILTON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 30th 1929

17

I HEREBY CERTIFY, That I attended deceased from June 17, 1929, to June 30, 1929.

that I last saw h alive on June 24, 1929.

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Unknown (duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Dr Bernard Lisk M. D.

, 19 (Address) 1716 N Calvert St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cem

DATE OF BURIAL: July 4 1929

20 UNDERTAKER: Martin W. E. Pipkins

ADDRESS: 37 [illegible]

Spec.—1-10-21—M&T—1500 Bks.

E 47323 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1-PLACE OF DEATH Womans Hospital

CITY OF BALTIMORE: (No. ..... ST. 26-1 WARD)

REGISTERED NO. E 47323

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna C. Bolbe

(a) RESIDENCE NO. 809 S. Clinton St

(Usual place of abode)

Length of residence in city or town where death occurred life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female

4 COLOR OR RACE white

5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Lloyd L. Bolbe

6 DATE OF BIRTH (month, day, and year) Feb 20 - 1904

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
25	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work H. W.

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Andrew Snyder

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Minnie Hebner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Lloyd L. Bolbe

(Address) 809 S. Clinton St.

15 Filed 1929 C. HAMPSON JONES, M. D.

By Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July - 1 1929

17

I HEREBY CERTIFY, That I attended deceased from June - 29 1929 to July - 1 1929.

that I last saw her alive on July - 1 - 1929.

and that death occurred, on the date stated above, at 11:04 P m.

The CAUSE OF DEATH* was as follows:

Criminal abortion of unknown origin

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary) Blood stream infection

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? 809 S. Clinton St.

Did an operation precede death? no Date of

Was there an autopsy? no

What tests confirmed diagnosis? Clinical

(Signed) Earle P. Clemson M. D.

19 (Address) Womans Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL 7/5 1929

20 UNDERTAKER Wm Cook

ADDRESS 1172 Park

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47324

CERTIFICATE OF DEATH

E 47324
REGISTERED NO.

1—PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. ST., 8-13 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sarah Yeager

(a) RESIDENCE NO. 1522 E. Chase ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? — yrs. — mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob Yeager

6 DATE OF BIRTH (month, day, and year) July 13-1846

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
82	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Zachariah Zech

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Sarah Yeager

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Records of
(Address) Baltimore City Hospitals

15 Filed L 2 - 1929, 19 H. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 19, 1926 to July 1, 1929, that I last saw her alive on July 1, 1929 and that death occurred, on the date stated above, at 3:00 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Marion [illegible] Lee, M. D.

7-1, 1929 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Prospect Hill York Pa	7/3 1929
20 UNDERTAKER William Cook	ADDRESS 1217 St Paul

Spec.—6-9-19—H. P. Co.—1000 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47325

CERTIFICATE OF DEATH.

E 47325

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE. (No.) 2015 Homewood St. (Ward) 16

2-FULL NAME John Sorber

(a) RESIDENCE. No. 2015 Homewood St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Margaret

6 DATE OF BIRTH (month, day, and year): Oct 20 1867

7 AGE: 61 Years 62 | Months 8 | Days 11 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Watchmaker

(b) General nature of industry, business, or establishment in which employed (or employer): Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: John Sorber

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Elizabeth Arspruch

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant (Address): Margaret Sorber 2015 Homewood

15 Filed 1929. C. HAMPSON JONES, M. D. Registrar

L 2 - 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 1 1929.

17 I HEREBY CERTIFY, That I attended deceased from November 1928; to July 1 1929.

that I last saw h~~e~~ alive on July 1 1929.

and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of Nov 1928.

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm Mitchell, M. D.

July 2 1929 (Address) 2901 Edmondson ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Norfolk Va	7/3 1929
20 UNDERTAKER: Wm Cook	ADDRESS: 1217 Park Ave St.

HON IS VERY important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47326

CERTIFICATE OF DEATH.

X 124 E 47326

REGISTERED NO.

1-PLACE OF DEATH U.S. Marine Hospital

CITY OF BALTIMORE: (No. Baltimore, Md. ST., 6-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Jiminez

(a) RESIDENCE NO. 18 N. Bond ST., WARD Maine

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs 4 mos. ds. How long in U. S., if of foreign birth? 18 yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----

6 DATE OF BIRTH (month, day, and year) Oct. 4, 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	8	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Able seaman

(b) General nature of industry, business, or establishment in which employed (or employer) Seaman

(c) Name of employer S.S. "Greylock"

9 BIRTHPLACE (city or town) (State or country) Mexico

PARENTS

10 NAME OF FATHER Frank Jiminez

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mexico

12 MAIDEN NAME OF MOTHER Lorenza Hernandez

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mexico

14 Informant Records, U.S. Marine Hospital (Address) Baltimore, Md.

15 Filed 6-2-1929, 19 F. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 29 19 29

17 I HEREBY CERTIFY, That I attended deceased from March 22, 19 29, to June 29, 19 29,

that I last saw h im alive on June 29, 19 29,

and that death occurred, on the date stated above, at 11:20 P m.

The CAUSE OF DEATH* was as follows:

Abscess of the liver

(duration) yrs. 4½ mos ds.

CONTRIBUTORY (Secondary) Suppurative pericarditis

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy

(Signed) Bradley L. Hodgkins, M. D.

7/2, 19 29 (Address) U.S. Marine Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Mary's Hampden	July 2, 1929
20 UNDERTAKER E. Leroy Stiffler & Inc.	ADDRESS 125 E. North Ave.

TION is very important. See [illegible] back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47327 — **CERTIFICATE OF DEATH** — 90 — **E 47327**

1—PLACE OF DEATH Baltimore City Hospitals — REGISTERED NO. .....

CITY OF BALTIMORE: (No. ..... ST. 5-8 ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Williams

(a) RESIDENCE NO. 432 N. Front ..... ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., If foreign birth? —yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Glazer

(b) General nature of industry, business, or establishment in which employed (or employer): ?

(c) Name of employer: ?

9 BIRTHPLACE (city or town) (State or country): ? Maine

PARENTS

10 NAME OF FATHER: Frank Williams

11 BIRTHPLACE OF FATHER (city or town) (State or country): ? Portugal

12 MAIDEN NAME OF MOTHER: Hanna Welch

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ? Ireland

14 Informant: Records of

(Address) Baltimore City Hospitals

15 Filed ..... HAROLD JONES, M. D. Registrar

L 7 - 1929 Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 28, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 31, 19 29, to June 28, 19 29,

that I last saw h.. im alive on June 28, , 19 29

and that death occurred, on the date stated above, at 9 P. M.

The CAUSE OF DEATH* was as follows:

Myocarditis, chr. Acute & incurable

..... (duration) over 4 yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

..... (duration) over 4 yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Typical Clinic

(Signed) [illegible] M. D.

....., 19 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

Hypertension and Senility Portugal

19 PLACE OF BURIAL, CREMATION OR RE... Forest Lawn — DATE OF BURIAL 7/2 19 29

20 UNDERTAKER [illegible] 7/3/29 ADDRESS [illegible]

Cor.—10-10-29—A Co.—100 Bks.

E 47328

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

128 E 47328

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Balt City Hospital St., 1-3 Ward)

2-FULL NAME Elizabeth Lochman

(a) RESIDENCE NO. 908 S Belnord Ave. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Andrew Lochman

6 DATE OF BIRTH (month, day, and year) Dec. 7 1877

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	51	7	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) at home
(c) Name of employer

9 BIRTHPLACE (city or town) Balto City
(State or country)

PARENTS

10 NAME OF FATHER Albert Albes

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto City

12 MAIDEN NAME OF MOTHER Caroline Father

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland

14 Informant Mrs. Jenat Kerbler
(Address) 908 S Belnord Ave

15 Filed JUL 2 1929 C. HAMPSON JONES, M. D. Registrar
By [illegible]

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Parenchymatous Nephritis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? 908 S Belnord Ave

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M. Fenton M. D.

7/2, 1929 (Address) 7002 Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Schwartz Cemetery — DATE OF BURIAL 7/4 1929

20 UNDERTAKER Wm Cook — ADDRESS 1217 S Bond

Or Death is to plain terms, so that it may be properly classified. Exact statement of occupation is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

Boland.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47329

CERTIFICATE OF DEATH

122-001

E 47329

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1300 N Fremont ST., (5-59 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret C Baland.

(a) RESIDENCE NO. 1300 N Fremont ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1875

7 AGE: Years 54 | Months | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore.

PARENTS

10 NAME OF FATHER: Thomas Boland.

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland.

12 MAIDEN NAME OF MOTHER: Catherine ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland.

14 Informant: M. Fahey's Sons Records.

(Address) 1827 W North Ave.

15 Filed 1-2-1929 H. [illegible] JONES, M. D. Registrar

By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7-1-29.

17 I HEREBY CERTIFY, That I attended deceased from Jan 15th, 19 29, to July 1st, 19 29, that I last saw h[illegible] alive on July 1st, 19 29 and that death occurred, on the date stated above, at 10 Lo P m.

The CAUSE OF DEATH* was as follows:

Cirrhosis of the Liver (Alcoholic)

(duration) yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis (duration) about 6 mos. — ds.

18 Where was disease contracted if not at place of death? Placed Acute

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Microscopic

(Signed) Wm Duncan, M. D.

7-2-1929 (Address) 1704 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Peters Cemetery — DATE OF BURIAL 7-3-29

20 UNDERTAKER: M. Fahey & Sons — ADDRESS 1827 W North Ave.

Spec.—2-29-28—L. F. S.—500 Blks.

E 47330

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 47330

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 632 N Washington ST., 9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Bertha Metzler

(a) RESIDENCE NO. 632 N Wash ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 56 yrs. mos. ds. How long in U. S., if foreign birth 56 yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, ~~Married~~, Widowed, or ~~Divorced~~, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank J Metzler

6 DATE OF BIRTH (month, day, and year): May 20 1842

7 AGE

Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
87	1	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Joseph Anft

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Louise N Hedges

(Address) 632 N Wash St

15 Filed 2-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): June 30. 29

17 I HEREBY CERTIFY, That I attended deceased from September, 1928, to June 30 1929, that I last saw h[illegible] alive on June 30, 1929 and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Valvular heart Disease

CONTRIBUTORY (Secondary) old age (duration) 1 yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A C Cecil M. D.

7/1, 1929 (Address) 1900 Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: ~~Loudon Park~~ Holy Redeemer DATE OF BURIAL: July 3 1929

20 UNDERTAKER: Geo. J. Derr ADDRESS: 156 N. Luzerne ave.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47331

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

161-002

E 47331

REGISTERED NO. 27-55

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3302 Menlo Drive ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Daley McCormack (Helen)

(a) RESIDENCE NO. 3302 Menlo Drive ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Wh.	Daly

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 30, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Edw. M. McCormack

11 BIRTHPLACE OF FATHER (city or town) (State or country) Richmond Va

12 MAIDEN NAME OF MOTHER Mary Bradley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Richmond Va

14 Informant mother
(Address)

15 Filed 2-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1-1929

17 I HEREBY CERTIFY, That I attended deceased from June 30, 1929, to July 1st, 1929, that I last saw her alive on July 1st, 1929 and that death occurred, on the date stated above, at 11 55 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage of new born

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Lob. Broncho-pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? By exam.

(Signed) L. Dalaglacca M. D.

, 19 (Address) 300 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	July 3-29
20 UNDERTAKER	ADDRESS
Redman & Son	1723 W Lafayette ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47332

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 173 W. Hamburg St., 23-31 WARD)

REGISTERED NO. 1671 E 47332

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Wallace

(a) RESIDENCE NO. 173 W. Hamburg ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colrd	—

a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) July 1- 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	—	—	—

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Dick Wallace

11 BIRTHPLACE OF FATHER (city or town) (State or country) Kentucky

12 MAIDEN NAME OF MOTHER Mary Thompson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mary Thompson

(Address) 173 W. Hamburg St

15 Filed 2 - 1929 C. HAMPSON JONES M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/1/29

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1929, to July 1, 1929,

that I last saw her alive on July 1st, 1929

and that death occurred, on the date stated above, at 10:50 A.M.

The CAUSE OF DEATH* was as follows:

Prematurity (6 mos)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) A. E. Bell, M. D.

19 (Address) 1734 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: HOPKINS HOSPITAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS — 1929

Spec.—2-29-28—L. F. S.—500 Bks.

E 47333

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1929 ✓ E 47333

REGISTERED NO. 7754

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2424 Rogers Ave. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Benno Kohn

(a) RESIDENCE NO. 2424 Rogers ST. Ave WARD
(Usual place of abode)

Length of residence in city or town where death occurred Lifetime How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE Clara L. Kohn

6 DATE OF BIRTH (month, day, and year) Sept. 25, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	9	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dept. Store

(b) General nature of industry, business, or establishment in which employed (or employer) Prop.

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Bernhard Kohn

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bavaria

12 MAIDEN NAME OF MOTHER Mathilda Lauer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bavaria

14 Informant Mrs. Clara Kohn (Address) 2424 Rogers Ave

15 Filed 2-1929 G. HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 - 1929

17 I HEREBY CERTIFY, That I attended deceased from December 16, 1928, to July 2, 1929, that I last saw h[illegible] alive on July 2, 1929 and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis - Chronic nephritis
Arterial hypertension

(duration) 11 yrs. mos. ds.

CONTRIBUTORY (Secondary) Unknown

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Major Symptoms

(Signed) Charles M. Austrian, M. D.

, 19 (Address) 1417 Eutaw Place

CHARLES M. AUSTRIAN, M.D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Har. Sinai Cem.	7/3/1929
20 UNDERTAKER Howard Sondheim	ADDRESS 15-20 W. Mt. Royal Ave

Spec.—2-29-28—L. F. S.—500 Bks.

Glassman 743 W Fayette

E 47334 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

43 E 47334

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 666 W Fayette ST. 4-25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James W Edlar

(a) RESIDENCE NO. 666 W Fayette ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma R

6 DATE OF BIRTH (month, day, and year) Jan 21 1845

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	84	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman 066

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer Retired

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER Helen Edlar

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Mary Edl

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Mrs Jane M Kennedy

(Address) 666 W Fayette

15 Filed JUL 3 1929 CLAYTON BOOKHULTZ, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1928, to June 30, 1929 that I last saw h alive on June 30, 1929 and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Sarcoma of Jaw

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) D Fany Glassman M. D.

July 2 1929 (Address) 2617 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn July 3

DATE OF BURIAL 1929

20 UNDERTAKER Wm Cook

ADDRESS 1217 St. Paul

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

Dyden hospital
91 - 0 & Elen - 36 4/5

E 47335
1—PLACE OF DEATH

CERTIFICATE OF DEATH

E 47335
REGISTERED NO.

CITY OF BALTIMORE (No. 506 West 28th ST. 12-51 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Georgia B Kelley

(a) RESIDENCE NO. 566 West 28th ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: John W. Kelley

6 DATE OF BIRTH (month, day, and year): March 4th 1852

7 AGE — Years: 77 Months: 4 Days: 27 If LESS than 1 day, hrs. or min.: 2

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

11 Informant: Ida B. Kelley
(Address) 506 West 28th

15 Filed 3-1929 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 1-1929

17 I HEREBY CERTIFY, That I attended deceased from Jun 14 1929, to July 1st 1929, that I last saw her alive on June 6th 1929 and that death occurred, on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Senile Paresis

(duration) yrs. mos. 16 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) W W Hindmarsh, M. D.

July 2 1929 (Address) 800 N Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — DATE OF BURIAL: 7/3- 1929

20 UNDERTAKER: William Cook — ADDRESS: 1217 St Paul

Spec.—2-29-28—L. F. S.—500 Bks.

E 47336 HEALTH DEPARTMENT—CITY OF BALTIMORE

90 ✓ E 47336

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 3-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Telka Rejiski

(a) RESIDENCE NO. 325 S. Bond ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? ? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	67?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) ? (State or country) Poland

PARENTS

10 NAME OF FATHER Thomas Pucharsky

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Poland

12 MAIDEN NAME OF MOTHER Catherine ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Poland

14 Informant Records of

(Address) Baltimore City Hospitals

15 Filed 7-3 1929 H. A. PATTISON JONES, M. D.
Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 24, 1929 to July 1, 1929, that I last saw her alive on July 1, 1929 and that death occurred, on the date stated above, at 7:45 P. m.

The CAUSE OF DEATH* was as follows:

Hypertension

Enlargement of heart c

Chronic myocarditis ?
(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

? (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Harry [illegible], M. D.

7-2, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary | DATE OF BURIAL July 4 1929

20 UNDERTAKER F. W. Ozazewski 1930 | ADDRESS Eastern Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

99-001

E 47337

CERTIFICATE OF DEATH

E 47337

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1029 S. Paca ST. 7-1-29 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Inez B. J. Long.

(a) RESIDENCE NO. 1029 S. Paca ST.,
(Usual place of abode)

WARD

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Mar 2nd 1926

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	3	4	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Harry J. Long.

11 BIRTHPLACE OF FATHER (city or town) (State or country) W. Va.

12 MAIDEN NAME OF MOTHER Margaret J. Pinkett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) W. Va.

14 Informant Harry J. Long.

(Address) 1029 S. Paca st.

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2nd 29

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1929, to July 2, 1929.

that I last saw h[illegible] alive on July 1, 1929

and that death occurred, on the date stated above, at 5 a m.

The CAUSE OF DEATH* was as follows:

Empyema of Lung.

CONTRIBUTORY (Secondary) Bronchitis (duration) 3 yrs. 2 mos. 14 ds.

18 Where was disease contracted if not at place of death? Home (duration) yrs. mos. 16 ds.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. C. Mc[illegible] M. D.

7/2, 1929 (Address) 990 Gaither Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Martinsburg W. Va. DATE OF BURIAL July 3 1929

20 UNDERTAKER Margaret G. Flynn ADDRESS 1422 Light.

JUL 3 - 1929 [illegible] M. D.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47338

CERTIFICATE OF DEATH

91-002

E 47338

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME DAVID C. SMITH

(a) RESIDENCE NO. 1209 Light St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	Widower

a If married, widowed, or divorced HUSBAND of (or) WIFE of Catherine Smith

6 DATE OF BIRTH (month, day, and year) May 20 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	1	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Richmond Va

PARENTS

10 NAME OF FATHER Geo. Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Operator (Address) 1836 Light St.

15 Filed JUL 3 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 29, 1929, to July 2, 1929, that I last saw him alive on July 1, 1929 and that death occurred, on the date stated above at 12 15 a.m.

The CAUSE OF DEATH* was as follows:

General arteriosclerosis

(duration) 5 yrs. 0 mos. 0 ds.

CONTRIBUTORY (Secondary) Arteriosclerotic gangrene of L. Leg (duration) 0 yrs. 0 mos. 7 ds.

18 Where was disease contracted if not at place of death? 1209 Light St.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis Clinical findings

(Signed) Addison Craft Kirby, M.D.

7-2, 1929 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse aide for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem. DATE OF BURIAL July 4 1929

20 UNDERTAKER Margaret D. Flynn ADDRESS 1422 Light St

Spec.—2-29-28—L. F. S.—500 Bks.

E 47339

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47339

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSPITALS ST., WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sarah Gertrude High

(a) RESIDENCE NO. 202 Hartford Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. 4 mos. 5 ds. How long in U. S., If foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George R. High

6 DATE OF BIRTH (month, day, and year) Feb. 27 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
83	82	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None old

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Fred Eutsins

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Hall

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Md.

14 Informant Records (Address) BALTIMORE CITY HOSPITALS

15 Filed JUL 5 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2, 1929

17 I HEREBY CERTIFY, That I attended deceased from 5-15, 1928, to 7-2, 1929, that I last saw h.. alive on 7-2, 1929 and that death occurred, on the date stated above, at 7-30 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis, general & cerebral

? over 1

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam.

(Signed) Sharon Hill M.D., M. D.

7-2, 1929 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem.	July 5 1929
20 UNDERTAKER Wm Tucker Sons	ADDRESS Mount Ha

Spec.—2-29-28—L. F. S.—500 Bks.

47340

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 100-001

E 47340

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital ST., 7-4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary West Stuart

(a) RESIDENCE NO. Sinai Hospital ST., WARD Lutherville Md

(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 5 ds. How long in U. S., if foreign birth? 71 yrs. 0 mos. 16 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6 If married, widowed, or divorced HUSBAND of (or) WIFE of: Harry F. Stuart

6 DATE OF BIRTH (month, day, and year): June 16 1858

7 AGE: Years 71 Months 0 Days 16 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer): none

(c) Name of employer: none

9 BIRTHPLACE (city or town) (State or country): Annapolis Maryland

PARENTS

10 NAME OF FATHER: Samuel G Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country): not known England

12 MAIDEN NAME OF MOTHER: Mary Dail

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Cambridge Maryland

14 Informant: Mr. Glen Stuart-(son)

(Address) Lutherville - Md

15 Filed 3 1929, 19

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7-2-29

17 I HEREBY CERTIFY, That I attended deceased from 6-28- 1929, to 7-2- 1929, that I last saw her alive on 7-2- 1929 and that death occurred, on the date stated above, at 2.10 p.m.

The CAUSE OF DEATH* was as follows:

Uraemia

CONTRIBUTORY (Secondary) (duration) 0 yrs. 0 mos. 5 ds. Cardiac failure

18 Where was disease contracted if not at place of death? (duration) yrs. mos. ds.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Chem. study of blood

(Signed) B. S. Cohen, M. D.

7/4 1929 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: July 4 1929.

20 UNDERTAKER: Leonard Hommel Co — ADDRESS: Balto

Cor.—10-10-29—A Co.—100 Bks.

E 47341

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

46 **E 47341**

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 224 S Streets St., 14-28 Ward)

2-FULL NAME Elicah Stonesifer

(a) RESIDENCE NO. 224 S. Streets St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Aly Stonesifer

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	43	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tailor
(b) General nature of industry, business, or establishment in which employed (or employer) 08
(c) Name of employer —

9 BIRTHPLACE (city or town) Austria
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Austria

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Austria

14 Informant Ida Stonesifer
(Address) 224 S. Streets

15 Filed ..... 19.. C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 1925

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to Death on the day stated above.

The CAUSE OF DEATH* was as follows:

Uremic Coma

Unknown (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas A Brooke M. D.

July 2. 1925 (Address) 3601 3rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Pk — DATE OF BURIAL July 4th 19 29

20 UNDERTAKER A. Jones — ADDRESS W. Baltimore

If DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

Harvey Jenell

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47342

CERTIFICATE OF DEATH

91-001

E 47342

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 768 Fine ST. 18-16 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harvey Jenell

(a) RESIDENCE NO. 768 Fine ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~: Sarah Jenell

6 DATE OF BIRTH (month, day, and year): 1880

7 AGE: Years 49. Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer on Boiler

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country): Richmond Va.

PARENTS

10 NAME OF FATHER: Abner Jenell

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Louise Nicholas

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Sarah Moore

(Address) 768 Fine St

15 Filed ..... 19 .....

Per .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 1 29

17 I HEREBY CERTIFY, That I attended deceased from June 9, 1929, to July 1, 1929 that I last saw him alive on July 1, 1929 and that death occurred, on the date stated above, at 1.55 m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Peritonitis

CONTRIBUTORY (Secondary) ..... (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? — (duration) yrs. mos. ds.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Frank E. Haun M. D.

7/2, 1929 (Address) 1006 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem DATE OF BURIAL 7-3 1929

20 UNDERTAKER: Leland Earley ADDRESS 916 Eutaw

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

2267 45 E 47343

CERTIFICATE OF DEATH.

E 47343

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 3-5 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Trimaldi

(a) RESIDENCE NO. 115 Lloyd St- ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

If married, widowed, or divorced HUSBAND of (or) WIFE of: Ralph Trimaldi

6 DATE OF BIRTH (month, day, and year): unknown

7 AGE: Years 29; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: H. W. 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): N. Y. City

PARENTS

10 NAME OF FATHER: Frank Galm

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. Y.

12 MAIDEN NAME OF MOTHER: May Unterman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N. Y.

14 Informant: Records (Address): JOHNS HOPKINS HOSPITAL

15 Filed: C. HENDERSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 1 1929

17

I HEREBY CERTIFY, That I attended deceased from June 29, 1929, to July 1, 1929,

that I last saw her alive on July 1, 1929,

and that death occurred, on the date stated above, at 7 10 a m.

The CAUSE OF DEATH* was as follows:

Meningococcus meningitis

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary): lumbar punctures x 3

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of July 1-

Was there an autopsy? yes

What test confirmed diagnosis? lumbar puncture + Smear

(Signed) I. Ridgeway Trimble, M. D.

(Address) I. Ridgeway Trimble

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer — DATE OF BURIAL: July 3 1929

20 UNDERTAKER: Frank V. Pakiton — ADDRESS: 2815 E Baltimore

TION is very important. See instructions on back of certificates.

Cor.—10-10-20—A Co.—100 Bks.

E 47344

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

179 E 47344

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) W. Balto Gen Hosp St. 70-69 Ward)

2-FULL NAME Roland Wolf.

(a) RESIDENCE NO. 2656 Lauretta Ave St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Divorced

6 DATE OF BIRTH (month, day, and year) Dec 6. 1900

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
28	6	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Hardwood Floor
(b) General nature of industry, business, or establishment in which employed (or employer) Scraper
(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER Ernest W. Wolf Jr.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto.

12 MAIDEN NAME OF MOTHER Isabelle Dilloch

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto. Md

14 Informant William Wolf
(Address) 2656 Lauretta Ave.

15 Filed ..... 19 C. HENDERSON JONES, M. D.
Registrar

7-23-1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) July 4th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest find that said deceased came to death on the day stated above.
(Inquest, autopsy or inquiry)

The CAUSE OF DEATH* was as follows:

Accident
3rd degree burns. Face
Back & Hands

CONTRIBUTORY (Secondary) Gave to explosion of gas (duration) yrs. ds.
in Kitchen 1642 Lauretta Ave

18 Where was disease contracted if not at place of death? 1642 Lauretta Ave (duration) yrs. mos.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) F. C. Regular Coroner. M. D.

July 5th 1929 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park DATE OF BURIAL July 4 1929

20 UNDERTAKER Frank K. Mauck ADDRESS Pikesville Md

Of DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47345

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47345

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hospitals St., (N. B.) WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Taylor

(a) RESIDENCE NO. 152 Port ave., Elizabeth, N.J. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	colored	Separated

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of Industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Flordia.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records
(Address)

15 Filed 7-1-1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 21, 1929, to July 1, 1929, that I last saw h im alive on July 1, 1929 and that death occurred, on the date stated above, at 8 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical and lab.

(Signed) Henry C. Smith M. D.

7-1-1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem. DATE OF BURIAL 7-3-1929

20 UNDERTAKER Daniel Eaton ADDRESS Balto

Cor.—10-10-29—A Co.—100 Bks.

E 47346

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

E 47346

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 611 N. Calvert St. St) 11-7 Ward)

2-FULL NAME George S. Lavender.

(a) RESIDENCE NO. 611 N. Calvert St. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Divorced.

5a If ~~married~~ or divorced HUSBAND of ~~WIFE~~ Ada E. Pickard.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	70	----------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired Actor.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Do not know.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant John Grieves.
(Address) 228 N. Carey St.

15 Filed ..... 19 CHARLTON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.
Acute dilatation of the Heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Reinhardt, M. D.

7/1, 1929 (Address) 1017 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross M. A. Co. DATE OF BURIAL 7-3rd 1929

20 UNDERTAKER Bernard C. Harlow ADDRESS 1000 S. Para St

JUL 3 1929

Important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Blks.

2265-64

E 47347

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 47347

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. WARD 7-4

2-FULL NAME Annie Cobb—

(a) RESIDENCE NO. Washington ST., WARD N—Car—
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Herman Cobb—

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE — Years: 33 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): N. Car—

PARENTS

10 NAME OF FATHER: James Degan

11 BIRTHPLACE OF FATHER (city or town) (State or country): N Car—

12 MAIDEN NAME OF MOTHER: Cinthia Tyrt

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N Car—

14 Informant: Ricardo—
(Address) JOHNS HOPKINS HOSPITAL

15 Filed 7-3-1929. I. C. HARRISON JONES, M. D. Registrar

BY HT

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 3 1929

17 I HEREBY CERTIFY, That I attended deceased from June 23 1929 to July 3 1929.

that I last saw her alive on July 3 1929.

and that death occurred, on the date stated above, at 7.45 a m.

The CAUSE OF DEATH* was as follows:

Brain tumor, malignant

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of June 26

Was there an autopsy? Yes Removal of tumor

What test confirmed diagnosis?

(Signed) I. Ridgeway Tumbly M. D.

July 3 1929 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Burlington N C — DATE OF BURIAL 7/3/29

20 UNDERTAKER: Joseph Ahrens — ADDRESS 221 Bway

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47348

CERTIFICATE OF DEATH

90

REGISTERED NO. E 47348

1—PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. ..... ST., 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Major Patterson

(a) RESIDENCE NO. 516 N. Central Ave. ST., ... WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Reason Patterson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: Sarah ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Records of

(Address) Baltimore City Hospitals

15 Filed 1-3-1929, 19 ..... Registrar

C. HERBERT JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 1 1929

17 I HEREBY CERTIFY, That I attended deceased from January 7, 1929 to July 1, 1929

that I last saw h... alive on July 1, 1929

and that death occurred, on the date stated above, at 4:45 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis chronic Senile

..... (duration) ? yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis, general Senile

..... (duration) ? yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Warren R. McCann, M. D.

7-1, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: W. Sm Cem

DATE OF BURIAL: July 3rd 1929

20 UNDERTAKER: Mrs J. G. Locks

ADDRESS: 1302 Ffeen

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47349

CERTIFICATE OF DEATH

129 E 47349

REGISTERED NO.

1—PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 2-4 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Stuttenburg

(a) RESIDENCE NO. 2002 Fleet ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): ? 040

(c) Name of employer: ?

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town): ? (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town): ? (State or country): Unknown

14 Informant: Records of

(Address) Baltimore City Hospitals

15 Filed 3 1929, 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 28, 1929

17 I HEREBY CERTIFY, That I attended deceased from October 22, 1920, to June 28, 1929, that I last saw him alive on June 28, 1929 and that death occurred, on the date stated above, at 5:30 p. m.

The CAUSE OF DEATH* was as follows:

Chronic diffuse Nephritis

(duration) 9 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) 9 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Phys. Exam. Lab. test

(Signed) [illegible] M. D.

6-29, 19 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

JUN 3 1929

Spec.—2-29-28—L. F. S.—500 Bks.

E 47350

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 47350

1—PLACE OF DEATH Baltimore City Hospitals — REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST., 5-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Archie Austin

(a) RESIDENCE NO. 219 Colvin ST., ... WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? —yrs. —mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	30			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) ? Odd Jobs

(c) Name of employer ?

9 BIRTHPLACE (city or town) ? (State or country) North Carolina

PARENTS

10 NAME OF FATHER William ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) North Carolina

12 MAIDEN NAME OF MOTHER Emma ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) North Carolina

14 Informant Records of
(Address) Baltimore City Hospitals

15 Filed ....., 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 30, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 29, 19 29 to June 30, 19 29, that I last saw him alive on June 30, 19 29 and that death occurred, on the date stated above, at 6:45 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

..... (duration) over 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Wound Thigh Accidental

..... (duration) ? yrs. ? mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Warren H. McClure, M. D.

7-1, 19 29 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
	19
20 UNDERTAKER	ADDRESS
	JUL 3 1929

Spec.—2-23-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47351 CERTIFICATE OF DEATH

91-002

E 47351

1—PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. 11-28 ST., WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Carter

(a) RESIDENCE NO. 314 W. Biddle ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	55?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) ?

(State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) ?

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ?

(State or country) Maryland

14 Informant Records of

(Address) Baltimore City Hospitals

15 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1, 1929

17 I HEREBY CERTIFY, That I attended deceased from December 29, 19 25, to July 1, 19 29,

that I last saw her alive on July 1, 19 29

and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Tuberculosis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Chart

(Signed) Herwin W. McLean, M. D.

7-1, 19 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND

DATE OF BURIAL JUL 3 19

20 UNDERTAKER ...

ADDRESS ...

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47352

CERTIFICATE OF DEATH

100-001

1—PLACE OF DEATH Balto City Hosp's

REGISTERED No. E 47352

CITY OF BALTIMORE: (No. Balto Md ST., 26-31 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mack Aliner

(a) RESIDENCE NO. Unknown ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	Black	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
33				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) Shipyard

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Balto City Hosp's
(Address)

15 Filed 1929 HARRY A. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6-30-29

17 I HEREBY CERTIFY, That I attended deceased from 6-11-, 1929, to 6-30-, 1929, that I last saw h[illegible] alive on 6-29-, 1929, and that death occurred, on the date stated above, at 2:30 p.m.

The CAUSE OF DEATH* was as follows:

Terminal Broncho Pneumonia
Alcoholic Delirium
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Alcoholic Psychosis Chronic
Alcoholic Delirium (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Harry H. Dossett, M. D.

6-30, 1929 (Address) Balto City Hosp's

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL 19
20 UNDERTAKER	ADDRESS

Spec.—1-10-21 M&T 1500 Bks.

E 47353 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

16 E 47353

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 14 W. Hill ST., 22-30 WARD)

2-FULL NAME Pauline N. Brannock

(a) RESIDENCE No. 14 W. Hill ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 15 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): June 17 1829

7 AGE: Years — Months — Days 15 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER W. P. Brannock

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER Eta Lumsden

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant W. P. Brannock

(Address) 14 W. Hill St.

15 Filed July 3 1929

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 2 1929

17 I HEREBY CERTIFY, That I attended deceased from June 28, 1929, to July 2, 1929, that I last saw her alive on July 2, 1929, and that death occurred, on the date stated above, at 5-15 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

CONTRIBUTORY (Secondary) (duration) Exhaustion yrs. mos 11 ds.

18 Where was disease contracted if not at place of death? — (duration) yrs. mos. 2 ds.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. L. Campbell M. D.

July 2, 1929 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem. DATE OF BURIAL July 3 1929

20 UNDERTAKER Margaret A. Flynn ADDRESS 1422 Light St

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47354

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

46 E 47354

1—PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (No. ..... ST. 5-8 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lillian Salter -

(a) RESIDENCE NO. 1008 E Lexington ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 12 1889

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
40	1	3	0

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 07

(b) General nature of industry, business, or establishment in which employed (or employer) Domestic

(c) Name of employer .....

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Henry Watts

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Henry Watts

(Address) 425 Orchard St

15 Filed 8 - 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-1-29

17 I HEREBY CERTIFY, That I attended deceased from 6-18, 1929, to 7-1, 1929, that I last saw her alive on 7-1 1929 and that death occurred, on the date stated above, at 6 25 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma ovary

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Paralytic ileus

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 6-28-'29

Was there an autopsy? No

What test confirmed diagnosis? Exploratory

(Signed) J Feyho, M. D.

7-1-'29 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary Cem

DATE OF BURIAL 7-3 1929

20 UNDERTAKER Geo. A. Felton

ADDRESS 1733 Druid Hill Ave

Spec.—2-29-25—L. F. S.—500 Bks.

E 47355 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001 ✓ E 47355

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3228 Eastern Ave ST. 76-2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John D. Johnson

(a) RESIDENCE No. 3228 Eastern Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of D. E. Johnson

6 DATE OF BIRTH (month, day, and year) April 13, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	2	19 18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md.

PARENTS

10 NAME OF FATHER John Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Kaudt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs John Hohmeister

(Address) 3228 Eastern Ave

15 Filed 3-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1, 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 20 '29 to July 1 1929 that I last saw him alive on July 1 1929 and that death occurred, on the date stated above, at 8 32 P. m.

The CAUSE OF DEATH* was as follows:

Apoplexy

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? (duration) 3 yrs. mos. ds.

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Hyfro Indicart Candida

(Signed) D. T. Mosher M. D.

7/1/29 (Address) 3015 Ellwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn Cem DATE OF BURIAL July 5 1929

20 UNDERTAKER H. Sander Sons Inc ADDRESS 1110 E Fort Ave

Spec.—2-29-28—L. F. S.—500 Bks.

E 47356 HEALTH DEPARTMENT—CITY OF BALTIMORE **E 47356**

CERTIFICATE OF DEATH

REGISTERED NO. 2864 129

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3701 Mohawk Ave ST., 7 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Katherine A. Gleichman

(a) RESIDENCE NO. 3701 Mohawk Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb. 12, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	4	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Gleichman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Amelia Albert

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Philip Volz

(Address) 3701 Mohawk Ave

15 Filed 3-1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1920, to July 2, 1929, that I last saw her alive on July 2, 1929 and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Valvular heart disease

(duration) several yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute nephritis Uremia

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? n/a

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) W. C. Surgeon, M. D.

, 19 (Address) 1702 Edison Pl.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem. DATE OF BURIAL July 5 1929

20 UNDERTAKER H. Sander Sons Inc ADDRESS 1704 Eutaw

Spec.—1-12-23—M&T—500 Blks.

E 47357

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 47357

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 4218 La Salle Ave. WARD) 26-42 92

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary E. Campbell

(a) RESIDENCE No. 4218 La Salle Ave. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Geo J. Campbell

6 DATE OF BIRTH (month, day, and year): Nov. 21-1862

7 AGE: Years 66 | Months 7 | Days 11 | If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Cumberland Md

PARENTS

10 NAME OF FATHER: Adam Bauer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Clara Keener

(Address) 4218 La Salle Ave.

15 Filed 3-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 2 1929

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1929, to July 2, 1929, that I last saw her alive on July 2, 1929, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas Semmes, M. D.

1929 (Address) 4206 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer

DATE OF BURIAL: 7-5 1929

UNDERTAKER: L. J. Rude

ADDRESS: 4408 Belair Ave

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

E 47358

CERTIFICATE OF DEATH.

90 E 47358

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 831 Hamilton Terrace (ST.) 11-24 (WARD)

2-FULL NAME Miss Bessie Gray

(a) RESIDENCE NO. 831 Hamilton Terrace ST. ..... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 ~~Single~~, ~~Married~~, Widowed, or Divorced, (write the word) Single

5a If ~~married~~, widowed, or ~~divorced~~ ~~HUSBAND of~~ (or) ~~WIFE~~ of

6 DATE OF BIRTH (month, day, and year) Nov 22nd 1866

7 AGE Years 73 Months 7 Days 10 If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ..... at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Usher Waterman

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Martha Luckett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Mr Ball (Address) 1146 Longwood St

15 Filed 4-[illegible]-29 Per ..... C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 17, 1926, to July 2, 1929, that I last saw h[illegible]r alive on July 2, 1929, and that death occurred, on the date stated above, at 3:30 m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

Ataxia (duration) 2 yrs. mos ..... ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Date of

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) O. N. Duvall, M. D.

July 3, 1929 (Address) 1817 N. Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount & Cem

DATE OF BURIAL July 6 1929

20 UNDERTAKER Henry Weber's Sons Co

ADDRESS [illegible]

FOR IS very important. See instructions on back of certificate.

Ezra Hollinger

E 47359

HEALTH DEPARTMENT--CITY OF BALTIMORE

47359

CERTIFICATE OF DEATH

X 100-20

1 PLACE OF DEATH — Registered No. C

City of Baltimore (No. 3601 Howard Park Ave St.: 64 Ward)

(If death occured in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2 FULL NAME Ezrah Hollinger

(Residence in Baltimore: No. 3601 Howard Park Ave St.: ~~70~~ yrs. ~~7~~ mos. 17 ds.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 SINGLE, ~~MARRIED~~ WIDOWED ~~OR DIVORCED~~ (Write the word): Widow

6 DATE OF BIRTH: Nov 17 (Month) (Day), 1838 (Year)

7 AGE: 90 yrs. 7 mos. 17 ds. — If LESS than 1 day, ... hrs. or ..... min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):

9 BIRTHPLACE (State or country): York Co. Penna.

PARENTS

10 NAME OF FATHER: Peter Zimmer

11 BIRTHPLACE OF FATHER (State or country): Penna.

12 MAIDEN NAME OF MOTHER: Matilda Rockenbar

13 BIRTHPLACE OF MOTHER (State or country): Penna.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Daniel H Kauffman

(Address) 3601 Howard Park Ave

15 Filed JUL 4 - 1929 C. HAMPSON JONES, M. D. REGISTRAR

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: July (Month) 4 (Day), 1929 (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 16, 1929, to July 4 1929.
that I saw h~~e~~ive on July 3 1929.
and that death occurred, on the date stated above, at 2.00 A.M.
The CAUSE OF DEATH* was as follows:

Bronchial Pneumonia

(Duration) yrs. 1 mos. 17 ds

Contributory (SECONDARY) —

(Duration) yrs. mos. ds.

(Signed) Jno Draughn M. D.

July 4, 1929 (Address) 701 K N Ave

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death: yrs. 7 mos. ds. — In the State: yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence: York Co Penna.

19 PLACE OF BURIAL OR REMOVAL: York Co Pa DATE OF BURIAL: July 7, 1929

Bermudian Creek Burial Ground

20 UNDERTAKER: J H Deming ADDRESS: 715 Lig[illegible]

State CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47360

CERTIFICATE OF DEATH

E 47360

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2623 Rosewood ave St., 15-58 Ward)

2-FULL NAME Jonas Herbst

(a) RESIDENCE No. 2623 Rosewood ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret Herbst

6 DATE OF BIRTH (month, day, and year) 3-9-1883

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	46	3	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Tinner
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Margaret Herbst
(Address) 2623 Rosewood ave

15 Filed 1929 C. HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-3 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ... death on the day stated above.

The CAUSE OF DEATH was as follows:

Coma Toxicum

Suicide

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Ira Mowbray M. D.

7/3 1929 (Address) 3632 Roland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Hesrun Rm — DATE OF BURIAL July 4 1929

20 UNDERTAKER Jacob Laws — ADDRESS 1439 E Baltimore

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47361
1—PLACE OF DEATH

REGISTERED No. **E 47361**

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Hebrew aged Home ST. 7-5-4 WARD)

2—FULL NAME Jacob Felsenfeld

(a) RESIDENCE NO. Belvedere & Greenspring ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? 50 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Anna Felsenfeld

6 DATE OF BIRTH (month, day, and year): April 10-1858

7 AGE: Years 72 | Months 2 | Days 22 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Mrs Rose Monroe

(Address) 2314 W. North Ave

15 Filed 4 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 3 1929

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1929, to July 3, 1929, that I last saw h[illegible] alive on July 3, 1929, and that death occurred, on the date stated above, at 6 30 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pancreas

(duration) 4-6 months yrs. mos. ds.

CONTRIBUTORY (Secondary): none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Stool examination

(Signed) Herman Seidel, M. D.

July 3 1929 (Address) Herman Seidel

*State the Disease Causing Death, or in deaths from Violent Causes state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale — DATE OF BURIAL: July 4 19 29

20 UNDERTAKER: Jack Lewis — ADDRESS: 1439 Eutaw St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47362

CERTIFICATE OF DEATH

90 E 47362

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Medical Arts Building.

City of Baltimore: (No. Cathedral & Read Sts. St., 9-46 Ward)

2-FULL NAME Michael J. Suess.

(a) RESIDENCE NO. 1759 Gorsuch Ave. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 64 yrs. 7 mos. 10 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White.	Married.

5a If married, HUSBAND of Emma M. Suess.

6 DATE OF BIRTH (month, day, and year) October 22, 1864

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	64	7	10	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Painter
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Emma M. Suess. (wife)
(Address) 1759 Gorsuch Ave.

15 Filed 1929 C. HAMPSON JONES, M. D. Registrar

L 4-1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.

Acute dilatation of the Heart.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Fenhiardt M. D.

7/8 . 1929 (Address) 107 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore County	July 6 . 1929
20 UNDERTAKER	ADDRESS
George J. Rust	1735 Hayward

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Eks.

E 47363 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129

Registered No. E 47363

1-PLACE OF DEATH

City of BALTIMORE: (No. 2819 Mosher St., 16-6 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J Gorman

(a) Residence No. 2816 Mosher St.,.....Ward.....
(Usual place of abode)

Length of residence in city or town where death occurred 82 yrs. 10 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX, Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Widowed

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Mary J Gorman

6-DATE OF BIRTH (month, day and year) Aug 9 1846

7-AGE. 82 yrs. 10 mos. 24 ds. If LESS than 1 day, ...hrs. or....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9-BIRTHPLACE (city or town) Baltimore
(State or Country), Md

PARENTS.

10-NAME OF FATHER, Brian Gorman

11-BIRTHPLACE OF FATHER (city or town) Ireland
(State or Country),

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) Ireland
(State or Country),

14-

(Informant) Frank Gorman

(Address) 2819 Mosher St

15-

Filed JUL 4 - 1929 HAMPSON JONES, M. D.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 3 1929

17- I HEREBY CERTIFY, That I attended deceased from May 4 1929 to July 3 1929

that I last saw h.. alive on July 3 1929

and that death occurred, on the date stated above, at 1 15 P. m.

The CAUSE OF DEATH* was as follows: Chronic Interstitial Nephritis

(Duration) yrs. 2 mos. ds.

CONTRIBUTORY
(Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Gross only

(Signed) L. G. Lolly M. D.

, 19 (Address) 351 Dulaney

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cem

DATE OF BURIAL, July 6 19 29

20-UNDERTAKER, H. C. Manning Son

ADDRESS 1136 Eutaw St

E 47364

1 PLACE OF DEATH

County University Hospital

Village or City Baltimore (No. ____ St.: ____ Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2 FULL NAME Florence Chambers (Res Elkridge, Md) 8 days

E 47364

STATE OF MARYLAND

CERTIFICATE OF DEATH

Registration Dist. No. ____

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word)
F	Colored	Married

6 DATE OF BIRTH: March 22, 1892 (Month) (Day) (Year)

7 AGE: 37 yrs. 3 mos. 12 ds. | If LESS than 1 day ____ hrs. or ____ min.?

8 OCCUPATION
(a) Trade, profession or particular kind of work: Housewife
(b) General nature of industry business, or establishment in which employed or (employer) ____ (37)

9 BIRTHPLACE (State or country): Md.

PARENTS

10 NAME OF FATHER: Alfred Blackstone

11 BIRTHPLACE OF FATHER (State or country): Md.

12 MAIDEN NAME OF MOTHER: Mary Steward

13 BIRTHPLACE OF MOTHER (State or Country): Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John Chambers.

(Address) Elkridge

15 Filed JUL 5 - 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH: July 4, 1929 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended the deceased from June 26, 1929 to July 4, 1929, that I last saw h[illegible] alive on July 4, 1929, and that death occurred on the date stated above, at [illegible] m.

The CAUSE OF DEATH * was as follows:

Edema of Pregnancy

(Duration) ____ yrs. ____ mos. ____ ds.

Contributory Secondary ____

(Duration) ____ yrs. ____ mos. ____ ds.

(Signed) Hamil S Bunker M. D.

July 7, 1929 (Address) Elkridge Md

*State the Disease Causing Death, or, in deaths from Violent Causes, state (1) Means of Injury and (2) Whether Accidental, Suicidal or Homicidal.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients or Recent Residents)

At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds.

Where was disease contracted, if not at place of death? ____

Former or usual residence ____

19 PLACE OF BURIAL OR REMOVAL: St Stephens Cemtry

DATE OF BURIAL: July 7, 1929

20 UNDERTAKER: Mary P Starr

ADDRESS: Ellicott City

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

Any information desired by the State Department of Health will be important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47365

CERTIFICATE OF DEATH

74-001

E 47365

REGISTERED NO.

1—PLACE OF DEATH Union memorial Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Colvert & 33rd ST. 12-20 WARD)

2—FULL NAME Anthony H. Myers

(a) RESIDENCE NO. 2309 Colvert ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Aug 18 1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	40.	11	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) St Louis Ky
(State or country)

PARENTS

10 NAME OF FATHER Herman Myers

11 BIRTHPLACE OF FATHER (city or town)
(State or country) St Louis.

12 MAIDEN NAME OF MOTHER Antonette Greving

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) St Louis

14 Informant Mrs Rondell

(Address) 1409 Standard Oil Bld. City

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3. 1929

17 I HEREBY CERTIFY, That I attended deceased from 6/30, 1929, to 7/3, 1929, that I last saw h— alive on 2/3, 1929 and that death occurred, on the date stated above, at 10 45P m.

The CAUSE OF DEATH* was as follows:

1 Hypertension
(Cerebral hemorrhage)
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage
(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Palma FC Williams, M. D.

7/3, 1929 (Address) Union Memorial Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Louis Missouri	July 5 1929.
20 UNDERTAKER	ADDRESS
Wm Cook	1217 St Paul.

7-5-1929 HAMILTON JONES M D

Spec.—2-29-28—L. F. S.—500 Bks.

E 47366 HEALTH DEPARTMENT—CITY OF BALTIMORE

1223 N. Caroline

CERTIFICATE OF DEATH

X 46 V E 47366

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1401 Fairfield Ave. ST.) REGISTERED NO. 9-18 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Clara Mae Keffel

(a) RESIDENCE NO. 1401 Fairfield Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. 5 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of John

6 DATE OF BIRTH (month, day, and year) May 7 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64		27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farm

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER John Haley

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaret Sullivan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Irene Keffel

(Address) 1401 Fairfield Ave

15 Filed JUL 5 - 1929 HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) June 27 1929

17 I HEREBY CERTIFY, That I attended deceased from June 27 —, 1929, to July 4, 1929, that I last saw her alive on July 1 —, 1929 and that death occurred, on the date stated above, at 5-10 a.m.

The CAUSE OF DEATH* was as follows:

Uterine Cancer

CONTRIBUTORY (Secondary) (duration) 3 yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Springfield, Ohio

Did an operation precede death? Yes Date of May 14-1927

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edwin B. Fenby, M. D.

7/4/29 (Address) 1223 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Spring Field Ohio — DATE OF BURIAL 1929

20 UNDERTAKER [illegible] & Co. — ADDRESS [illegible]

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47367

CERTIFICATE OF DEATH

74-001

E 47367

1—PLACE OF DEATH

REGISTERED NO. 19-56

CITY OF BALTIMORE: (No. BALTIMORE CITY HOSPITALS STREET OR WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ellen Smith

(a) RESIDENCE NO. 2614 Greenmount ST. Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) APRIL 4 - 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70 ?	3		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) ? (State or country) Md.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) ?

14 Informant Records of (Address) BALTIMORE CITY HOSPITALS

15 Filed JUL 5 - 1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4 - 1929

17 I HEREBY CERTIFY, That I attended deceased from 2-24, 1921, to 7-3, 1929, that I last saw her alive on 7-3, 1929 and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage into cerebrum & V.T.
Hemiplegia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) over 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Here

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Warren H. Wilson, M. D.

7-4, 1929 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge — DATE OF BURIAL 7/6 1929

20 UNDERTAKER J. Bellamy Co 16 — ADDRESS 1217 St Paul St.

Stec—12-23-21—E.B.R.S.—400 Bks.

E 47368

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161 901

E 47368

Registered No. .....

1-PLACE OF DEATH

City of BALTIMORE: (No. 6321 N. Carey St. 16 76 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Marguerite Farrer

(a) Residence No. 632 N. Carey St., Ward.

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE, Black

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) June 25, 1929

7-AGE. ....yrs. ....mos. 2 ds. If LESS than 1 day, ...hrs. or ....min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.....

(b) General nature of industry, business, or establishment in which employed (or employer).....

(c) Name of employer.....

9-BIRTHPLACE (city or town) Baltimore Md. (State or Country),

PARENTS.

10-NAME OF FATHER, Walter Farrer

11-BIRTHPLACE OF FATHER (city or town) Morgantown (State or Country), W. Va.

12-MAIDEN NAME OF MOTHER, Minnie McLaurin

13-BIRTHPLACE OF MOTHER (city or town) Hamlet (State or Country), North Carolina

14-

(Informant).....

(Address).....

15-

FILED. JUL 5 - 1929

C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 2, 1929

17- I HEREBY CERTIFY, That I attended deceased from June 25 19 29 to July 2 19 29 that I last saw h.. alive on July 1 19 29 and that death occurred, on the date stated above, at 12.00 noon. The CAUSE OF DEATH* was as follows:

Pneumonia 27 hrs.

(Duration) ....yrs. ....mos. ....ds

CONTRIBUTORY (Secondary)

(Duration) ....yrs. ....mos. ....ds

18-Where was disease contracted if not at place of death?.....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Xavier A. Kourgiansis M. D.

7/2, 1929 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. MARYLAND

DATE OF BURIAL. ....., 19....

20-UNDERTAKER. [illegible] Tudor Davis,

ADDRESS [illegible] JUL 3 1929

Instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47369

CERTIFICATE OF DEATH

E 47369

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3237 Lunt St ST. 25-76 WARD

2—FULL NAME Bessie Louise Schultz

(a) RESIDENCE NO. 3237 Lunn ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6 DATE OF BIRTH (month, day, and year): June 6 '29

7 AGE — Years | Months | Days 28 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Louis Schultz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Mary Sirotta

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Louis Schultz

(Address) 3237 Lunn St

15 Filed JUL 5 - 1929 SHANNON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3, 1929.

17 I HEREBY CERTIFY, That I attended deceased from June 28, 1929, to July 3, 1929, that I last saw h[illegible] alive on July 1, 1929 and that death occurred, on the date stated above, at 4 00, m.

The CAUSE OF DEATH* was as follows:

Mal Nutrition

(duration) yrs. 1 mos. — ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Abe Krantz, M. D.

, 19 (Address) 1324 Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross C.G. — DATE OF BURIAL: July 5 1929

20 UNDERTAKER: Fred Cranston — ADDRESS: 766 Edmondson

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 47370

REGISTERED NO. 179 E 47370

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Franklin Square Hosp St. [illegible] Ward)

2-FULL NAME Mary Frances Brehm

(a) RESIDENCE NO. 315 S. Goodyear, St. _____ Ward _____

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. _____ mos. _____ ds. How long in U. S., if of foreign birth? _____ yrs. _____ mos. _____ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): April 10 1927

7 AGE — Years: 2 — Months: 2 — Days: 23 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md

PARENTS

10 NAME OF FATHER: Harlan Brehm

11 BIRTHPLACE OF FATHER (city or town): Balto.

(State or country): Md.

12 MAIDEN NAME OF MOTHER: Mary _____

13 BIRTHPLACE OF MOTHER (city or town): Balto

(State or country): Md

14 Informant: Mrs Mary Brehm

(Address): 315 S. Goodyear St

15 Filed L 5-1929 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 3 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Shock & Burns from Sitting in pot of boiling water

(duration) _____ yrs. _____ mos. _____ ds.

CONTRIBUTORY (Secondary)

(duration) _____ yrs. _____ mos. _____ ds.

(Signed) Harold Brooke M. D.

(Coroner) 3601 3rd Ave

July 4. 1929 (Address) S W Bns.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cem Date of Burial July 6th 1929

20 UNDERTAKER: Joseph B Cook ADDRESS 1003 N Balto St

If DEATH is from any form of violence, state whether it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

Aemiliana

E 47371

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47371

REGISTERED NO.

1—PLACE OF DEATH St Joseph's Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Caroline ST., WARD)

2—FULL NAME Sister Mary Aemiliana Shilling

(a) RESIDENCE NO. Glen Riddle ST. Pa. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. / ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (Write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 17 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	3	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Religious Nun

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John Schilling

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catharine Gradeaux

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Records of St Joseph's Hospital

(Address) Caroline & Aisquith Sts

15 Filed 5-1929, 19 H. LEE JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-4-29

17 I HEREBY CERTIFY, That I attended deceased from 7-3-29, 19, to 7-4-29, 19,

that I last saw h alive on 7-4-29, 19

and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Myocarditis with Extensive Cardiac decompensation

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia Bilateral

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Infirmary

Did an operation precede death? No Date of None

Was there an autopsy? No

What test confirmed diagnosis? Clinical Course

(Signed) W W Landrey, M. D.

7/6, 19 29 (Address) St Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	July 6 1929
20 UNDERTAKER	ADDRESS
Henry Hough Sons & Co.	130 E Eager St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47372

CERTIFICATE OF DEATH

90 E 47372

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2019 E. Oliver St., 8-17 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Hirtz

(a) RESIDENCE NO. 2019 E Oliver ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary G. Hirtz

6 DATE OF BIRTH (month, day, and year): Oct 11 = 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	8	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Govt. Guard

(b) General nature of industry, business, or establishment in which employed (or employer): Distillery

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John Hirtz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Margaret Hurst

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Mary Hirtz

(Address): 2019 E Oliver St

15 Filed JL 5 1929, 19 [illegible] Registrar

[illegible] JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7-3-29

17 I HEREBY CERTIFY, That I attended deceased from 6-18, 1928, to 7-3, 1929, that I last saw him alive on 7/3, 1929, and that death occurred, on the date stated above, at 10 P m.

The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) 1 yrs. mos. 4 ds.

CONTRIBUTORY (Secondary): Myocardial Degeneration

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Signs

(Signed) David Weiss, M. D.

7/5, 1929 (Address) 1500 Broadway

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltocem — DATE OF BURIAL: 7/6 1929

20 UNDERTAKER: Henry Lutz — ADDRESS 1203 N. Broadway

Spec.—2-29-28—L. F. S.—500 Bks.

E 47373

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74 001

E 47373

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2917 Guilford av ST.) (17-50 WARD)

2—FULL NAME Carolina Koch Austin

(a) RESIDENCE NO. 2917 Guilford av ST., 17 WARD
(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. 2 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles S Austin

6 DATE OF BIRTH (month, day, and year) Jan 24, 1867

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
62	5	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer) Mother

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER John Henry Koch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margaretta Boehme

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Franklin C Austin (Son)

(Address) 2035 - 32nd St

15 Filed July 5 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4/1929.

17 I HEREBY CERTIFY, That I attended deceased from June 1st, 1929, to July 4, 1929, that I last saw h[er] alive on July 3rd 1929 and that death occurred, on the date stated above, at 6:10 a.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Mitral endocarditis Hemiplegia

Of left side

(duration) — yrs. 6 mos. 4 ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of ?

Was there an autopsy? Yes

What test confirmed diagnosis? ?

(Signed) J. Wesley Bruce, M. D.

7/5, 1929 (Address) 100 S. Chapel St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn	July 6 1929
20 UNDERTAKER	ADDRESS
Louis Heumann	3 S Broadway

Spec.—2-29-28—L. F. S.—500 Bks.

E 47374

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

88 E 47374

1—PLACE OF DEATH

CITY OF BALTIMORE; (No. 1606 Carlos Terrace ST.) 12-19 (WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Landon

(a) RESIDENCE NO. 1606 Carlos Terrace ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	C	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) May 20. 1907

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	22	1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D.C.

PARENTS

10 NAME OF FATHER Washington London

11 BIRTHPLACE OF FATHER (city or town) (State or country) Washington D.C

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington D.C.

14 Informant Mrs Bertha Scott

(Address) 1606 Carlos Terrace

15 Filed 5 1929, 19 C. HAMILTON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 31 1929

17 I HEREBY CERTIFY, That I attended deceased from April 25 19 29 to July 31 19 29

that I last saw h alive on July 30 19 29

and that death occurred, on the date stated above, at 5-A, m.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) yrs. 2 mos. 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. T. Hatcher M. D.

8/3 19 29 (Address) 1 W Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Cavalry Cemetery — DATE OF BURIAL 8/5 1929

20 UNDERTAKER Mrs Chas D. Bailey — ADDRESS 1721 Jefferson St

Spec.—2-29-28—L. F. S.—500 Bks.

E 47375

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

+ 100-00

E 47375

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1411 Gilmor St., W. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mildred Cooper

(a) RESIDENCE NO. 1405 Pennsylvania Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	S

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 4/6/1926

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	3	2	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) Child

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt. Md.

PARENTS

10 NAME OF FATHER Jno W Cooper

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balt. Md.

12 MAIDEN NAME OF MOTHER Alta M Bordley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balt. Md.

14 Informant Howard Reeves

(Address)

15 Filed 5-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/4/29

17

I HEREBY CERTIFY, That I attended deceased from 7/4/29, 19..., to 7/4/29, 19...,

that I last saw h... alive on 7/4/29, 19...,

and that death occurred, on the date stated above, at 8 P.M.

The CAUSE OF DEATH was as follows:

Ruptured Tubercular Pregnancy

CONTRIBUTORY (Secondary) Toxemia (duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? Home (duration) yrs. mos. ds.

Did an operation precede death? No Date of

Was there an autopsy? No Clinical

What test confirmed diagnosis?

(Signed) Jno Thompson Jones M. D.

(Address) 1411 Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pine Grove — DATE OF BURIAL July 7 1929

20 UNDERTAKER P. Mackenzie Son — ADDRESS White Hall Md

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47376

CERTIFICATE OF DEATH.

90 E 47376

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 400 N. Fulton Ave Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Warner.

(a) RESIDENCE NO. Home for the Aged of the U.E. Church

(Usual place of abode)

Length of residence in city or town where death occurred 56 yrs. mos. ds. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Aug 8 - 1852

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	76	10	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Retired

9 BIRTHPLACE (city or town)

(State or country) England

PARENTS

10 NAME OF FATHER Wm. Warner.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) England

12 MAIDEN NAME OF MOTHER Harriett Hutchinson

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) England

14

Informant

(Address)

FILED JUL 5 - 1929 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3 1929

17

I HEREBY CERTIFY, That I attended deceased from January 1, 1929 to July 3, 1929, that I last saw him alive on July 3, 1929, and that death occurred, on the date stated above, at 10 p m.

The CAUSE OF DEATH* was as follows:

Valvular Heart disease

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary) Grippe

(duration) yrs. mos. 15 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Methods

(Signed) George C. Shannon, M. D.

(Address) 700 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Date of Burial July 5 1929

20 UNDERTAKER George J. Smith ADDRESS 1552 Hollins St

very important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

E 47377

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 47377

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Church Home & Infirmary Ward) Clayton

2-FULL NAME Mrs. Margaret Clayton

(a) RESIDENCE NO. Church Home & Infirmary Ward

(Usual place of abode)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 ~~Single~~ Married, Widowed, or Divorced. (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: James J Clayton

6 DATE OF BIRTH (month, day, and year): Aug 5 1853

7 AGE: 73 Years 74 | Months 10. | Days 18. | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None 37

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Balto. Md

(State or country)

PARENTS

10 NAME OF FATHER: James Deaver

11 BIRTHPLACE OF FATHER (city or town): Balto. Md

(State or country)

12 MAIDEN NAME OF MOTHER: Margaret Towson

13 BIRTHPLACE OF MOTHER (city or town): Balto. Md

(State or country)

14 Informant: Harry B Clayton

(Address) 2502 Eldorado

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7-3-29 19

17 I HEREBY CERTIFY, That I attended deceased from 1-1 19 29 to July 3 19 29

that I last saw her alive on July 1 19 29

and that death occurred, on the date stated above, at 11 30 a. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

Myocarditis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Isaac R. Guy

, 19 (Address) Church Home & Infirmary, M. D.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery Date of Burial July 8 1929

20 UNDERTAKER: William J. Schaefer ADDRESS 1816 Mount

very important. See instructions on back of certificates. Exact statement of OCCUPATION is

Spec.—1-10-21—M&T—1500 Bks.

47378

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 47378

1-PLACE OF DEATH Sinai Hospital

CITY OF BALTIMORE: (No. 15-68 ST. WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Ida Nathan

(a) RESIDENCE NO. 2104 Westwood ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Solomon Nathan

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE Years 68 Months Days If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Jack Lewis (Address) 1439 Bank

15 Filed 7-5-1929 WILLIAMSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5 1929

17 I HEREBY CERTIFY, That I attended deceased from 7-3, 1929, to 7-5, 1929, that I last saw h alive on 7-5, 1929, and that death occurred, on the date stated above, at 7:20 a.m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Failure

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Arteriosclerosis - Chronic Myocarditis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Were Clinical

(Signed) B. J. Cohen M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rodphale DATE OF BURIAL 7-5 1929

20 UNDERTAKER Jack Lewis ADDRESS 1439 Bank

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47379

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47379

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 718 E. Chase ST., 10-14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME David Bowen

(a) RESIDENCE NO. 718 E. Chase ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if foreign birth 65 yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widower

6a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~: late Mary Ann Bowen

6 DATE OF BIRTH (month, day, and year): July 14/44

7 AGE — Years: 84 | Months: 11 | Days: 13 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Stone Cutter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Wales

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Wales

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Wales

14 Informant: Mrs Emma Dahle

(Address) 718 E Chase St

15 Filed JUL 5 - 1929 WILLIAM H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 2/29

17 I HEREBY CERTIFY, That I attended deceased from June 7th 29 to July 2 29

that I last saw h alive on 19

and that death occurred, on the date stated above, at 1.55 P. m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

Duration: yrs. mos. ds.

CONTRIBUTORY (Secondary): Myocarditis Duration: yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm B Lennon M. D.

7/3 1929 (Address) 718 N Calhoun St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge

DATE OF BURIAL: 7/5 1929

20 UNDERTAKER: Philip Herwig

ADDRESS 2066 Eutaw St

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47380

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 231 Sidney Ave ST. WARD)

REGISTERED NO. 161 001 E 47380

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Boy O'Connell.

(a) RESIDENCE NO. 231 Sidney Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 4 1929

7 AGE Years Months Days If LESS than 1 day 4 hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Joseph D. O'Connell.

11 BIRTHPLACE OF FATHER (City or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Gladys Seymour

13 BIRTHPLACE OF MOTHER (City or town) (State or country) Balto Md.

14 Informant Gladys O'Connell

(Address) 231 Sidney Ave.

15 Filed JUL 5 1929 19 ITAMSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4 1929.

17 I HEREBY CERTIFY, That I attended deceased from July 4 1929. to July 4 1929.

that I last saw him alive on July 4 1929

and that death occurred, on the date stated above, at 6 15 P m.

The CAUSE OF DEATH* was as follows:

Prematurity

(6 months)

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) A. P. Van Gelder M.D. M. D.

19 (Address) 530 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL July 5 1929

20 UNDERTAKER Mr. & Mrs. John H. Tempel & Son

ADDRESS 801 W. Fayette

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47381 | CERTIFICATE OF DEATH | ×4 E 47381

1—PLACE OF DEATH

REGISTERED NO. .....

CITY OF BALTIMORE: (No. University Hospital St. 4-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Daniel Botzon

(a) RESIDENCE NO. Myrtle Ave. Essex Md. WARD Essex Md.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 64 yrs. mos. 8 ds. How long in U. S., if foreign birth? 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Karoline Botzon

6 DATE OF BIRTH (month, day, and year) Feb 23-1865

7 AGE	Years	Months	Days 11	If LESS than 1 day, hrs. or ... min.
	64	4	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

14 Informant Karoline Botzon

(Address) Myrtle Ave Essex

15 Filed JUL 5 1929, 19... H. HAROLD JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 26, 1929, to July 7, 1929, that I last saw him alive on July 7, 1929 and that death occurred, on the date stated above, at 12:25 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of the Caecum.

(duration) 1 yrs. 6 mos. 7 ds.?

CONTRIBUTORY (Secondary) Broncho pneumania

(duration) ... yrs. ... mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of June 26, 1929

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Luther E. Leitch M. D.

July 8, 1929 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oaklawn Cemetery	July 6 1929
20 UNDERTAKER	ADDRESS
George W. Jenkins	1737 E. Eager St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47382 E 47382

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Mercy Hospital ST., 13-33 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Mary E. Gorman

(a) RESIDENCE NO. 3561 Resnick Rd WARD A

(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John J. Gorman

6 DATE OF BIRTH (month, day, and year) Feb 24 1875

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
54	4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Jamie V. Gorman

(Address) 3561 Resnick Road

Filed JUL 5 - 1929 WILLIAM R. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 23, 1929, to July 3, 1929, that I last saw h[illegible] alive on July 3, 1929 and that death occurred, on the date stated above, at 9 40 p. m.

The CAUSE OF DEATH* was as follows:

Tuberculous Peritonitis & Salpingitis

Cardiac Failure

(duration) yrs. 3+ mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. + mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 5/28/29

Was there an autopsy? No

What test confirmed diagnosis? Clinical & operative.

(Signed) David Feuer, M. D.

7/7, 1929 (Address) Mercy Hospital (Residence 2903 Springhill Ave.)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hampstead	July 6 1929
20 UNDERTAKER Edmondson & Son	ADDRESS 3415 Eastern Ave

Spec.—2-29-28—L. F. S.—500 Bks.

E 47383 Buchan

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

45 E 47383

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. Balt. City Hosp. ST. 10-31 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jacob Buchan

(a) RESIDENCE NO. O'Donnell c 22nd ST., WARD.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~~yrs.~~ mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Buchan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Record

(Address)

15 Filed ..... 19 ..... Registrar

C. HAMPSON JONES, M. D.

7-5-1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/4/29

17 I HEREBY CERTIFY, That I attended deceased from 6/20, 1929, to 7/4, 1929, that I last saw h alive on 7/4, 1929 and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of rectum

Stricture of rectum

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Secondary anemia

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. M. Hampson, M. D.

7/5, 1929 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel — DATE OF BURIAL July 5, 1929

20 UNDERTAKER Wendell & Heppel — ADDRESS 36 & 2 Eut

Spec.—2-29-28—L. F. S.—500 Blks.

E 47384

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47384

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 15-66

CITY OF BALTIMORE: (No. 2004 N. Smallwood St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Florence Evelyn Wahrna

(a) RESIDENCE NO. 2004 N. Smallwood St. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles F Wahrna.

6 DATE OF BIRTH (month, day, and year) June 28. 1875

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	54		6.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Robert Powell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Florida

12 MAIDEN NAME OF MOTHER Kenneth Keene

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore.

14 Informant Ruth Schumacher

(Address) 2004 N. Smallwood St.

15 Filed ....., 19 .... Registrar

HAMPSON JONES, M. D. 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-4-29

17

I HEREBY CERTIFY, That I attended deceased from May 28, 1929, to July 4, 1929, that I last saw h.. alive on July 4, 1929 and that death occurred, on the date stated above, at 9 20 A. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast mets

Carcinoma of the liver

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 1927

Was there an autopsy? No

What test confirmed diagnosis? No

(Signed) H. H. H. Meyers, M. D.

M. S. , 19 29 (Address) 2838 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	7-8-29
20 UNDERTAKER M Fahey & Sons	ADDRESS 1824 W Baltimore

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47385

CERTIFICATE OF DEATH

31

E 47385

1—PLACE OF DEATH — REGISTERED NO. 913

CITY OF BALTIMORE: (No. 927 N. Dunbar St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Herbert Bailey

(a) RESIDENCE NO. 927 N. Dunbar st. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: C.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Apr. 7, 1904

7 AGE: Years 25 | Months 2 | Days 26 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Smithfield Va

PARENTS

10 NAME OF FATHER: Jack Bailey

11 BIRTHPLACE OF FATHER (city or town) (State or country): Smithfield Va

12 MAIDEN NAME OF MOTHER: Elizabeth Driggs

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Mary R Hinson

(Address) 1721 Ashland ave

15 Filed 5-1929, 19 — C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 3, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 24, 1929, to July 3, 1929, that I last saw him alive on June 29, 1929, and that death occurred, on the date stated above, at 19 m.

The CAUSE OF DEATH* was as follows:

Pulmonary T.B.C.

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Hemmorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R. S. Young, M. D.

7/2, 1929 (Address) 1424 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Smithfield Va — DATE OF BURIAL: July 5, 1929

20 UNDERTAKER: Mrs. P. G. Elliott — ADDRESS: 1720 Ashland

Spec.—1-12 23—M&T—500 Blks.

E 47386 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47386

CERTIFICATE OF DEATH.

90

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 119 N. Pearl ST., 4-25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosario Cammarata

(a) RESIDENCE No. 119 N. Pearl ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Antonia Fedele

6 DATE OF BIRTH (month, day, and year) March 24-1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	61	4	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fruit dealer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Pasquale Cammarata

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Chas. Cammarata

(Address) 2436 W. Baltimore St.

15 Filed 7-5-1929 C. HAMPSON JONES, M. D. Registrar

By Rieth

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-3 1929

17 I HEREBY CERTIFY, That I attended deceased from 6-29, 1929, to 7-2, 1929 that I last saw him alive on 7-2, 1929 and that death occurred, on the date stated above, at 11 a-m.

The CAUSE OF DEATH* was as follows:

General Arteriosclerosis with Hypertentia - Mitral regurgitation

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) cardiac decompensation (duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) S. Imarco M. D.

7-5, 1929 (Address) Medical attended.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemtery DATE OF BURIAL 7/6 1929

20 UNDERTAKER Geo L. Ruth ADDRESS 1735 Harford ave

THIS is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 47387 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47387

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 101 N. Linwood Ave St. 6-11 Ward) Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Ebert

(a) Residence No. 101 N. Linwood Ave. St. Ward.
(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? 60 yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Sophia Ebert

6-DATE OF BIRTH (month, day and year) July 20 1848

7-AGE. 81 yrs. mos. ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Stevedore

(b) General nature of Industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Germany

PARENTS.

10-NAME OF FATHER. Lawrence Ebert

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Germany

12-MAIDEN NAME OF MOTHER. Schwartz

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Germany

14-

(Informant) Mr. George Ebert

(Address) 101 N Linwood Ave

15-

Filed 5 - 1929 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 3 29

17-I HEREBY CERTIFY, That I attended deceased from May 1 19 29 to July 3 19 29

that I last saw h. alive on July 3 19 29

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Sorynx

(Duration) 2 mos. 2 ds.

CONTRIBUTORY (Secondary) Cardiac Exhaustion

(Duration) yrs. mos. 2 ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) William J. Dyer M.D.

(Address) 801 N Linwood

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem.	July 6 19 9.

20-UNDERTAKER	ADDRESS
Frank V. Pipitone	2818 E. Balto St.

Instructions on back of Certificate.

Cor.—12-9-25—A Co.—200 Bks.

E 47388

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Dr Morrissey
74-801 36 Roland
E 47388

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No.) 403 West 23rd St., 12-51 Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Adam Rennie

(a) RESIDENCE NO. 403 West 23rd St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec 2 1859

7 AGE: Years 70 Months 7 Days 3

IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clerk

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: J. J. Hughes

9 BIRTHPLACE (city or town)

(State or country): Scotland

PARENTS

10 NAME OF FATHER: William Rennie

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Scotland

12 MAIDEN NAME OF MOTHER: Catherine Evans

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Scotland

14 Informant: Agnes S. Rennie

(Address) 403 West 23rd St

15 Filed 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

(Signed) (Coroner) M. D.

July 5, 1929 (Address) 3632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet Cemetery Date of Burial July 6 1929

20 UNDERTAKER: William Cook ADDRESS 1217 St Paul

Cor. Dec. 9, 1925—A Co.—200 Bks.

IMPORTANT—Before filling out this certificate, read carefully the instructions on the back of the certificate. Every question must be answered, or a penalty may be imposed. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47389

CERTIFICATE OF DEATH

90

E 47389

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3603 Yolando Road ST. 9-47 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie E. Kearney

(a) RESIDENCE NO. 3603 Yolando Road ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Patrick Kearney

6 DATE OF BIRTH (month, day, and year) May 20 1844

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	85	1	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) New Castle Va. (State or country)

PARENTS

10 NAME OF FATHER M. Jackson

11 BIRTHPLACE OF FATHER (city or town) Va. (State or country)

12 MAIDEN NAME OF MOTHER Sarah Summerfiel

13 BIRTHPLACE OF MOTHER (city or town) Va. (State or country)

14 Informant Edwin W. Elder

(Address) 3603 Yolando Road

15 Filed 5-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-4-29

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1929, to July 4, 1929, that I last saw h[illegible] alive on July 4, 1929, and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Tabular Heart Disease

contributory

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? by symptoms

(Signed) Wesley A Cox M. D.

7/5, 1929 (Address) 541 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery

DATE OF BURIAL 7/6 1929

20 UNDERTAKER I. Few McCully

ADDRESS 130 E Fort

Spec.—1-12-23—M&T—500 Bks.

E 47390 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 47390

1-PLACE OF DEATH Home for Incurables

CITY OF BALTIMORE: (No. 40th Street & Cedar Ave. ST. 12-50 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Anna Eliza Bowie

(a) RESIDENCE No. Normandie Apts. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Carlton W. Bowie

6 DATE OF BIRTH (month, day, and year) [illegible]

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	74	0	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None (House work)

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Rolesburg West Virginia

PARENTS

10 NAME OF FATHER John Westly Heckmann

11 BIRTHPLACE OF FATHER (city or town) Easton (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Esther Johnson

13 BIRTHPLACE OF MOTHER (city or town) Bristol (State or country) Pennsylvania

14 Informant Mrs Nettie B Copenhaver (Address) 2624 St Paul St Baltimore

15 Filed 5-1929 G. HAMPSON JONES, M. D. Registrar by Rep

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4 1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 12 1928, to July 3rd 1929 that I last saw her alive on July 3rd 1929, and that death occurred, on the date stated above, at 8:45 a.m.

The CAUSE OF DEATH* was as follows:

Chronic Infectious Arthritis (duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Interstit. neph. Uremia (duration) — yrs. 2 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical diagnosis

(Signed) W. W. Mayo, M. D.

7/5, 1929 (Address) Medical Arts Building

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cemetery DATE OF BURIAL July 6 1929

20 UNDERTAKER Stewart & Mowen. ADDRESS Balto

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 47391 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

49 E 47391

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1007 Hayward Ave. ST. 27-55 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Geo. Burgers

(a) RESIDENCE No. 1024 Hayward Ave. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Husband of Mrs. Catherine Burgers

6 DATE OF BIRTH (month, day, and year) 7/9/1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
✓	78	11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Non-retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt. Md

PARENTS

10 NAME OF FATHER Burgers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known " "

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Harry Burgers (Address) 1024 Hayward ave

15 Filed 7-5 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/4 1929

17 I HEREBY CERTIFY, That I attended deceased from 3/24, 1929 to 7/4, 1929, that I last saw him alive on 7/3, 1929 and that death occurred, on the date stated above, at 8:10 A m.

The CAUSE OF DEATH* was as follows:

Cancer Cachexia

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Malignancy of Stomach

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Examination

(Signed) H. A. Sigrist M. D.

, 19 (Address) 924 N. Charles

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery — DATE OF BURIAL July 6 1929

20 UNDERTAKER Stewart & Mowen Company — ADDRESS Balto. Md

Spec.—2-29-28—L. F. S.—500 Bks.

E 47392

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 47392

1—PLACE OF DEATH

REGISTERED NO.

BALTIMORE CITY HOSPITALS

CITY OF BALTIMORE: (No. 10-15 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Geo. L. Benson

(a) RESIDENCE NO. 636 E. Madison ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., If foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Widower ?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	85			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) ? Md.

PARENTS

10 NAME OF FATHER John Benson

11 BIRTHPLACE OF FATHER (city or town) (State or country) ? Md.

12 MAIDEN NAME OF MOTHER Christine ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ? Md.

14 Informant Records of BALTIMORE CITY HOSPITALS (Address)

15 Filed 6-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-4-29

17 I HEREBY CERTIFY, That I attended deceased from 8-7, 1928, to 7-4, 1929, that I last saw h[illegible] alive on 7-4, 1929 and that death occurred, on the date stated above, at 1:00 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

over 2 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

over 2 (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) [illegible], M. D.

7-5, 1929 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Cem	7-6 1929
20 UNDERTAKER	ADDRESS
Jas. H. Skinner	1625 E. Baad St

Spec.—2-29-28—L. F. S.—500 Bks.

E 47393

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47393

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 719 N. Carrollton Ave. WARD) 16-23

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James J. Driggs

(a) RESIDENCE NO. 719 N. Carrollton Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of: Not known

6 DATE OF BIRTH (month, day, and year): Aug. 6 - 1886

7 AGE: Years 42 | Months 10 | Days 29 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Box Factory

(c) Name of employer: Not known

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not known

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not known

14 Informant: Mrs. Emma Brown

(Address): 719 N. Carrollton Ave.

15 Filed 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 2 1929

17 I HEREBY CERTIFY, That I attended deceased from July 1st 1929 to July 2nd 1929

that I last saw h[illegible] alive on July 2nd 1929

and that death occurred, on the date stated above, at 5:40 A m.

The CAUSE OF DEATH* was as follows:

Acute Gastritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute dilatation of Heart

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) A. Cole M. D.

. 19 (Address) 1120 Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cemtry

DATE OF BURIAL: 7/6 1929

20 UNDERTAKER: Geo. T. A. Gibson

ADDRESS: 1733 Druid Hill Ave.

Spec.—1-12-23—M&T—500 Blks.

E 47394

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47394

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Provident Hospital

CITY OF BALTIMORE: (No. 1514 Dennis ST. 23-31 WARD)

REGISTERED NO. 101-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Myrtle Ruffin Drummond

(a) RESIDENCE No. 149 W. Hamburg ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	colored	child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of infant

6 DATE OF BIRTH (month, day, and year) Dec - 1928

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
~~7 mth~~		7	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Ambrose

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Ambrose

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital records

(Address) C. HAMPSON JONES, M.D.

Filed JUL 6 1929, 19 Per [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/4 1929

17 I HEREBY CERTIFY, That I attended deceased from 7-2, 1929, to 7-4, 1929, that I last saw him alive on 7-7, 1929, and that death occurred, on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Lobar pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) convulsions

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? 149 W. Hamburg St.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo. McDonald, M. D.

, 19 (Address) Provident Hospt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL (a) Mt Zion (b)

DATE OF BURIAL July 6 1929

20 UNDERTAKER J. L. Brown's Son

ADDRESS 1026 W Mulberry

Spec.—2-29-28—L. F. S.—500 Bks.

E 47395 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47395

CERTIFICATE OF DEATH

31

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Baltimore City Hospitals (ST.) 12-31 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Johnson

(a) RESIDENCE NO. 803 Warner st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1/27/1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53	5	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chair stainer

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER William Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records

(Address)

15 Filed 6-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 20 1929, to July 5 1929, that I last saw h ill alive on July 5, 1929 and that death occurred, on the date stated above, at 3.45 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis Clinical and lab.

(Signed) Henry C Smith M. D.

7-5-, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery — DATE OF BURIAL 7/8 1929

20 UNDERTAKER William Cook — ADDRESS 1217 St Paul

Spec.—1-12-23—M&T—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47396

CERTIFICATE OF DEATH.

E 47396

REGISTERED NO. 100201

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5811 Merville Ave ST. 27-55 WARD

2-FULL NAME Durrett Paul Reed

(a) RESIDENCE NO. 5811 Merville Ave ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 24th 29

7 AGE Years Months Days 11 If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Charles Reed

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Miriam Young

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Miriam Young

(Address) 5811 Merville Ave

15 Filed 6-1929 by C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5th 1929

17 I HEREBY CERTIFY, That I attended deceased from June 24th, 1929, to July 5th, 1929, that I last saw him alive on July 5th, 1929, and that death occurred, on the date stated above, at 9 P. m

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical diagnosis

(Signed) J. B. Silverhood M. D.

7/6, 1929 (Address) 1901 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Mary's Lauspden

DATE OF BURIAL 7/6 1929

20 UNDERTAKER Wareham Coord.

ADDRESS 1217 St Paul St.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47397

CERTIFICATE OF DEATH

100-001

E 47397

1-PLACE OF DEATH

City of Baltimore: (No. 124 N. Mount St. 14-27 Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Jas. albert Parker

(a) RESIDENCE NO. 124 N Mount St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 8 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 30, 1928

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	8	4	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto - Md
(State or country)

PARENTS

10 NAME OF FATHER Arthur Luther Parker

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Mystel Brown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Mystel Parker
(Address) 124 N. Mount

15 Filed ....., 19.... C. HARRISON JONES, Registrar

6-1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho - Pneumonia

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Chas H Brooke M. D.

July 4. 1929 (Address) 3601 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Zion Cemetery	July 6, 1929
20 UNDERTAKER Mrs Katie R. Williams	ADDRESS 3221 Schroeder St

Of Death in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47398

CERTIFICATE OF DEATH

E 47398

1-PLACE OF DEATH

REGISTERED NO. 182

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of Baltimore: (No. Pier No.2 Pratt St. St. 02-33 Ward)

2-FULL NAME Charles Hurley.(O) (Hardy)

(a) RESIDENCE NO. 723 Brennan Court. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. ---- mos. ---- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	40	----------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Virginia.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Daisy Carter.(C)
(Address) 728 Brennan Court.

15 Filed ..... 19 .....
7-6 1929 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 1, 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Drowning.
Accidental fall from a wharf.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Reinhardt, M. D.

7/5. 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Cemetery

DATE OF BURIAL July 6, 1929

20 UNDERTAKER Mrs Katie R. Williams

ADDRESS 3224 Schroeder St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

E 47399

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓ E 47399

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 12 S. Calhoun ST., 14-28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Pauline Askey

(a) RESIDENCE NO. 12 S. Calhoun ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 77 yrs. 8 mos. 4 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

3a If married, widowed, or divorrd HUSBAND of (or) WIFE of Joseph Askey

6 DATE OF BIRTH (month, day, and year) Oct. 31, 1851

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	8	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland

PARENTS

10 NAME OF FATHER Francis P. Jordan

11 BIRTHPLACE OF FATHER (city or town) Baltimore
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Catherine Ballentine

13 BIRTHPLACE OF MOTHER (city or town) Baltimore
(State or country) Maryland

14 Informant Estelle Askey
(Address) 12 S. Calhoun Street

15 Filed 7-8-1929, 19 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4, 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 5, 19 29, to July 4, 19 29, that I last saw her alive on July 3, 19 29 and that death occurred, on the date stated above, at 5 15 P. m.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease.

(duration) 2 yrs. 3 mos. 0 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contrartrd if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry F. Buettner, M. D.

19 (Address) 1319 Light St, Balto, Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	7/8 19 29

20 UNDERTAKER Henry U. Mears & Son ADDRESS 805 N. Calvert

Spec.—2-29-28—L. F. S.—500 Bks.

E 47400 HEALTH DEPARTMENT—CITY OF BALTIMORE **E 47400**

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 105 S Payson ST. 20-28 WARD) REGISTERED NO. 47

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary M. Cantwell

(a) RESIDENCE NO. 105 S Payson ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 54 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of late John Cantwell

6 DATE OF BIRTH (month, day, and year) May 5th 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) /

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER Unknown.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary McEvoy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs. Anna M Taylor
(Address) 105 S Payson St.

15 Filed 6-1929, 19 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4th 1929.

17 I HEREBY CERTIFY, That I attended deceased from May 1- 1929. to July 4th 1929.
that I last saw h alive on July 4 1929
and that death occurred, on the date stated above, at 1.45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast with Metastasis to brain

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Injury of skull

(Signed) Chas A Cook M. D.

(Address) 105 N Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery DATE OF BURIAL July 8th 1929

20 UNDERTAKER John J. Cowan & Son ADDRESS 90 Hollins St

Spec.—2-29-28—L. F. S.—500 Bks.

E 47401

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-0 1/2

E 47401

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Maryland Gen. Hosp. ST., 1300 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Girl Sheridan

(a) RESIDENCE NO. 705 W. 36th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7-4-29

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER John F. Sheridan

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Md.

12 MAIDEN NAME OF MOTHER Loretta E. Fredrick

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Md

14 Informant Hospital Records

(Address)

15 Filed 7-6-1929 C. HAMPSON JONES, M. D. Registrar By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-4-29

17

I HEREBY CERTIFY, That I attended deceased from 7.30 A.M., 19..., to 9.15 A.M., 19...,

that I last saw h... alive on..., 19...

and that death occurred, on the date stated above, at ... m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Premature separation of placenta (duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) ... M. D.

, 19 (Address) Church Home Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hopkins	19
20 UNDERTAKER	ADDRESS

Spec.—1-10-21—M&T—1500 Bks.

E 47402

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1929 E 47402
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai hospital ST., 7-13 WARD) Frank

2-FULL NAME Sarah Whitehill

(a) RESIDENCE NO. Sinai Hospital ST., WARD
(Usual place of abode)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

Length of residence in city or town where death occurred 63 yrs. 6 mos. 22 ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	widow

5a If married, widowed, ~~or divorced~~
HUSBAND of
(or) WIFE of Mr. W. Frank

6 DATE OF BIRTH (month, day, and year) Dec 13 1865

7 AGE	Years	Months	Days	If LESS than 1 day ~~hrs. or min.~~
	63	6	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John Whitehill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bavaria Germany

12 MAIDEN NAME OF MOTHER Rose Stern

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md.

14 Informant Mrs. E. C. Whitehill
(Address) 2405 E. North Ave.

15 Filed 6-7 1929 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-5 1929

17 I HEREBY CERTIFY, That I attended deceased from 6-30 1929 to 7-5 1929.

that I last saw her alive on 7-5 1929.

and that death occurred, on the date stated above, at 12.40 P. m.

The CAUSE OF DEATH* was as follows:

hypertensive cardio-vascular renal dis.

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) hemiplegia - (left)

(duration) 2 yrs. 0 mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical study

(Signed) [illegible], M. D.

1929 (Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION ~~OR REMOVAL~~ Loudon Pk. Crematory DATE OF BURIAL 7/8 1929

20 UNDERTAKER David Londrigan ADDRESS 1820 W. Fayette Ave.

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47403

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

65-002

E 47403

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 7219 Park Heights Ave WARD 24 25)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Louis S. Hutzler, Jr.

(a) RESIDENCE NO. 7219 Pk. Heights Ave WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life time How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 14 1917

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	12	3	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md.

PARENTS

10 NAME OF FATHER Louis S. Hutzler

11 BIRTHPLACE OF FATHER (city or town) Balto. (State or country) Md.

12 MAIDEN NAME OF MOTHER Theresa Strauss

13 BIRTHPLACE OF MOTHER (city or town) Balto. (State or country) Md.

14 Informant Charles Hutzler
(Address) 7219 Pk. Heights Ave.

15 Filed ..... 19 ..... HAMPSON JONES, M. D.
6-1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5, 1929.

17 I HEREBY CERTIFY, That I attended deceased from August 20, 1928, to July 5, 1929, that I last saw h... alive on July 5, 1929 and that death occurred, on the date stated above, at 3.20 P. m.

The CAUSE OF DEATH* was as follows:

Hodgkin's Disease

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Tracheal Atresis; Asphyxia

(duration) — yrs. — mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Microscopic examination of a Clipped gland

(Signed) Louis P. Hamburger, M. D.

19 (Address) 1207 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Har Sinai Cem	7/7/1929
20 UNDERTAKER	ADDRESS
David Sondheim	1120 W. Mt. Royal Ave.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47404

HEALTH DEPARTMENT—CITY OF BALTIMORE

38 √ E 47404

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1406 E. Fairmount Ave. WARD) 5-9

2—FULL NAME Jamious Robinson

(a) RESIDENCE (Usual place of abode) NO 1406 E. Fairmount Ave ST., WARD

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: colored

5 Single, Married, Widowed or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Melinda Robinson

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE — Years: 46 — Months: — Days: — If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: David Robinson

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Betty Sample

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Melinda Robinson

(Address) 1406 E. Fairmount Ave.

15 Filed: 7-3-29, H. HAMPSON JONES, M. D. Registrar

1328

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2-1929

17 I HEREBY CERTIFY, That I attended deceased from June 25, 1929 to July 2, 1929, that I last saw h[illegible] alive on July 2, 1929, and that death occurred, on the date stated above, at 12:45 P. m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Contributory

(duration) 1 yrs. 14 mos. ds.

CONTRIBUTORY (Secondary) Accidental Injuries

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Yes

(Signed) C. O. Stellwagen, M. D.

July 2, 1929 (Address) 508 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ashburn Cemetery — DATE OF BURIAL: July 6 1929

20 UNDERTAKER: Chas. H. Johnson — ADDRESS: 146 N. Eutaw St.

Spec.—1-12-23—M&T—500 Bks.

E 47405 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47405

CERTIFICATE OF DEATH.

100-01

1-PLACE OF DEATH

REGISTERED NO. 28-64

CITY OF BALTIMORE: (No. 5201 Fernpark Ave ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Nora May Evans

(a) RESIDENCE NO. 5201 Fern Park Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred L. yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE W.

5 ~~Single, Married~~, Widowed, or ~~Divorced~~. (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Robert L Evans

6 DATE OF BIRTH (month, day, and year) Apl 26-1879

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
50	2	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER George McCann

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Harriett Fritz

13 BIRTHPLACE OF MOTHER (city or town) Germa (State or country)

14 Informant Mrs Thelma Evans (Address) 5201 Fern Park ave

15 Filed . 19 C. HAMPSON JONES, M. D. Registrar

-1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 30, 1929, to July 5, 1929, that I last saw her alive on July 5, 1929, and that death occurred, on the date stated above, at 10.45 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Wm. A. Straus, M. D.

7/6, 1929 (Address) 1901 Griffiths

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery DATE OF BURIAL July 8 1929

20 UNDERTAKER Richard Gross ADDRESS 2324 Lafayette Ave

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 47406 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47406

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: (No. Caton & Wilkens Ave ST. 75-12 57 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Mary Coward

(a) RESIDENCE NO. 1st Ave Lansdowne Md ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 18 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Wm Coward

6 DATE OF BIRTH (month, day, and year) Apr 8 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59	2	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Peter Rossiter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ire

12 MAIDEN NAME OF MOTHER Donahmon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Wm. Coward

(Address) 1st Ave Lansdowne Md

15 Filed 7-6 . 1929 HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-4 1929

17 I HEREBY CERTIFY, That I attended deceased from 6-19 . 1929 . to 7-4 . 1929 , that I last saw her alive on 7-4 . 1929 , and that death occurred, on the date stated above, at 4 45 P m.

The CAUSE OF DEATH* was as follows:

Diabetes mellitus

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Marietta De Bonelli M. D.

. 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Johns Cemetery Catonsville Md — DATE OF BURIAL 7/8/1929

20 UNDERTAKER J. A. Moran — ADDRESS 306 E Baltimore

Spec.—2-29-28—L. F. S.—500 Bks.

E 47407 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 ✓ E 47407

1—PLACE OF DEATH

REGISTERED NO. 72 31

CITY OF BALTIMORE: (No.) Baltimore City Hospitals ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Calvin Jones

(a) RESIDENCE NO. 204 W. Henrietta st. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Peggy Jones

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Longshoreman

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Amos Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

14 Informant Hospital Records

(Address)

15 Filed 7-7-29 C. HAMPSON JONES, M. D. Registrar

By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1929, to July 5, 1929, that I last saw him alive on July 5, 1929, and that death occurred, on the date stated above, at 12.25 A. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical and lab.

(Signed) Henry Smith M. D.

7-5-1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Known Virginia

DATE OF BURIAL 7/6 1929

20 UNDERTAKER Frank T. Lemley

ADDRESS 578 W Baltimore

Spec.—2-29-28—L. F. S.—500 Bks.

E 47408

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47408

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 4-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lewis Frazier

(a) RESIDENCE NO. Towson, Md. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 7 yrs. — mos. 20 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Married

a If married, widowed or divorced HUSBAND of (or) WIFE of Angeline Frazier

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	34			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Chauffeur.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland.

PARENTS

10 NAME OF FATHER Alexander Frazier

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Rachel Howder

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

11 Informant Hospital Records.

(Address)

15 Filed 6-1929 H. C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/3/29

17 I HEREBY CERTIFY, That I attended deceased from 6/13/29, 19 , to 7-3-29, 19 , that I last saw him alive on 7-3-29, 19 and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Keratoma of testicle

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Metastasis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes. Date of 6-18-29

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) Lewis P. Gundry, M. D.

7-4-1929 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cem. Towson Md. DATE OF BURIAL 7/6 1929

20 UNDERTAKER Samuel P. Beverley ADDRESS 578 N. Eutaw

Spec.—2-29-28—L. F. S.—500 Bks.

E 47409

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 47409

1—PLACE OF DEATH

REGISTERED NO. 14-20

CITY OF BALTIMORE: (No. 1829 Penna Ave ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Andrew J Engel

(a) RESIDENCE NO. 1829 Penna Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ella M. Engel

6 DATE OF BIRTH (month, day, and year) Feb 17 1874

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
55	4	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Harness Maker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer for Self

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Conrad Engel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Eliz. ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Ella M Engel

(Address) 1829 Penna Ave

15 Date 6-1929 C. HAMPSON JONES, M. D. Registrar Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4th 1929

17 I HEREBY CERTIFY, That I attended deceased from April 26 1929, to July 4 1929, that I last saw h alive on July 3d 1929 and that death occurred, on the date stated above, at 4.45 a. m.

The CAUSE OF DEATH* was as follows:

Endocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Pleurisy with effusion

(duration) yrs. 1/2 mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Leon Hemmeter M. D.

7/5 1929 (Address) 3002 Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Pauls Violettsville	7-6 1929

20 UNDERTAKER Mrs Chas G Rehde ADDRESS 2327 Edmondson Ave

Spec.—2-29-28—L. F. S.—500 Bks.

E 47410 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47410

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3302 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry A. Schwarzkopf

(a) RESIDENCE NO. 3362 Parkside Drive ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. 11 mos. 5 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Josephine E. Schwarzkopf

6 DATE OF BIRTH (month, day, and year) July 30 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	11	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Sergt. in Balto. Police Department

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER John Schwarzkopf

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Magdalena Gross

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Miss Hilda M. Schwarzkopf

(Address) 3302 Parkside Drive

15 C. HAMPSON JONES, M. D. Registrar

7-6-1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5 1929

17 I HEREBY CERTIFY, That I attended deceased from July 3, 1929, to July 5, 1929, that I last saw him alive on July 5, 1929, and that death occurred, on the date stated above, at 4:30 P m.

The CAUSE OF DEATH* was as follows:

Cerebral Embolism

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) General Sclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) Geo. L. Zimmerman

7/6, 1929 (Address) 935 E Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: July 8 1929

20 UNDERTAKER: Henry Strauss Sons Inc. — ADDRESS: 120 E Eager

Spec.—2-29-28—L. F. S.—500 Bks.

E 47411

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47411

CERTIFICATE OF DEATH

129

1—PLACE OF DEATH

REGISTERED NO. 19-28

CITY OF BALTIMORE: (No. 216 S. Mount ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Leah Litchfield

(a) RESIDENCE NO. 216 S Mount ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 4 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
71	70	11	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Montgomery Co Md

PARENTS

10 NAME OF FATHER James Crandall

11 BIRTHPLACE OF FATHER (city or town) (State or country) Montgomery Co Md

12 MAIDEN NAME OF MOTHER Harriett Hamilton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Montgomery Co Md

14 Informant Grafton Litchfield

(Address) 216 S Mount St

15 Filed 6-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4, 29

17 I HEREBY CERTIFY, That I attended deceased from 6.28, 1929, to 7.4, 1929, that I last saw her alive on 7.4, 1929 and that death occurred, on the date stated above, at 4.30 P.M.

The CAUSE OF DEATH* was as follows: Myocarditis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) agn

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) L. D. Gilpatrick, M. D.

7.5, 1929 (Address) 711 N. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	July 6 1929
20 UNDERTAKER George Smith	ADDRESS 1532 Hollins

Spec.—1-10-21—M&T—1500 Bks.

E 2 6 8 21
E 47412

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

57 E 47412

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL S. 7-West WARD)

2-FULL NAME Doris Baldwin

(a) RESIDENCE NO. 3211 E. Southern avenue WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-residents give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 13/12

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
16	10	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER Edward Baldwin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER Lilly Baker

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Record

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUL 7 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5 - 1929

17 I HEREBY CERTIFY, That I attended deceased from July 2 , 1929 , to July 5 , 1929 , that I last saw her alive on July 5 , 1929 , and that death occurred, on the date stated above, at 5 30 A m.

The CAUSE OF DEATH* was as follows:

Diabetic acidosis

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted, if not at place of death?

Did an operation precede death?

Was there an autopsy? no

Confirmed diagnosis? Blood & urine chemistry

(Signed) James Baldwin, M. D.

7-5-1929 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Mem.

DATE OF BURIAL: 7/8 1929

20 UNDERTAKER: Philip Herwig

ADDRESS 2016 Orleans st

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47413

CERTIFICATE OF DEATH

90

E 47413

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) 4007 Hamilton Ave (Street) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Louise C. Meyer

(a) RESIDENCE NO. 4007 Hamilton Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of — daughter of Chas L. & Mary Meyer

6 DATE OF BIRTH (month, day, and year) July 11/80

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
48	11	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto.

PARENTS

10 NAME OF FATHER Chas. L. Meyer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger.

12 MAIDEN NAME OF MOTHER Mary M Hommel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto.

14 Informant Mrs. C. C. Rettberg

(Address) 4007 Hamilton Ave

15 FILED 6 - 1929 (19) HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4/29

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1924, to July 4th, 1929, that I last saw h[illegible] alive on July 2nd, 1929 and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Chr. Endocarditis

Edema

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wallis W. White M. D.

7/5, 19 29 (Address) 2800 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem.	July 6, 19 29
20 UNDERTAKER	ADDRESS
2016 Philip Herring	2016 Orleans St

Spec.—2-29-28—L. F. S.—500 Bks.

E 47414 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 47414

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2435 Mc Elderry ST., 710 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry Ferdinand Becker

(a) RESIDENCE NO. 2435 Mc Elderry ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S., if foreign birth? 37 yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Augusta Becker

6 DATE OF BIRTH (month, day, and year) June 7, 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66	0	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cement contractor

(b) General nature of industry, business, or establishment in which employed (or employer) 86

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger

14 Informant Paul Becker
(Address) 2421 Mc Elderry st

15 [illegible] 6 - 1929, 19 HAMPSON Jones M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4/29

17 I HEREBY CERTIFY, That I attended deceased from June 4, 1929 to July 4, 1929, that I last saw him alive on July 4, 1929, and that death occurred, on the date stated above, at 10 55 p.m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis v uremia

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arterio sclerotic Cardio Ves. disease

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. Sheldon Tootell M. D.

19 (Address) 323 Medical Arts Bldg.,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Trinity Cem.

DATE OF BURIAL 7/8 1929

20 UNDERTAKER Philip Herwig

ADDRESS 206 Orleans st.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47415 ✓ E 47415

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Univ Hosp ST. 4-20 (WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Thompson

(a) RESIDENCE NO. Crisfield Md. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Lillian Thompson.

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Painter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Hosp Records.

(Address)

15 Filed 6-1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/6/29

17

I HEREBY CERTIFY, That I attended deceased from 5/29, 1929, to 7-6, 1929, that I last saw h[illegible] alive on 7-6, 1929, and that death occurred, on the date stated above, at 9.08 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of prostate

CONTRIBUTORY (Secondary) Uremia (duration) 10 yrs. mos. ds.

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Clinical & X-Ray.

(Signed) Lewis P. Tuttle, M. D.

July 6th 1929 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Crisfield Md. DATE OF BURIAL July 9th 1929

20 UNDERTAKER E. A. Tawes ADDRESS 1000 S. Paca St.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

226830.

CERTIFICATE OF DEATH.

E 47416

1-PLACE OF DEATH E 47416

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 16-23 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Mary West.

(a) RESIDENCE No. 1126 Moshier St. ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: black

5 Single, Married, Widowed, or Divorced, (write the word): Separated

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: unknown

6 DATE OF BIRTH (month, day, and year): 1881

7 AGE — Years: 48 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): unknown

(c) Name of employer: unknown

9 BIRTHPLACE (city or town) (State or country): md.

PARENTS

10 NAME OF FATHER: Robert Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country): md.

12 MAIDEN NAME OF MOTHER: Kate Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): md.

14 Informant: Records.

(Address) JOHNS HOPKINS HOSPITAL

Filed JUL 7 - 1929 [illegible] M. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7-4-1929

17

I HEREBY CERTIFY, That I attended deceased from 7-2-, 1929 to 7-4-, 1929.

that I last saw her alive on 7-4-, 1929.

and that death occurred, on the date stated above, at 9 30 a. m.

The CAUSE OF DEATH* was as follows:

Chronic nephritis

Hypertensive Heart Disease

Acute Cardiac failure.

(duration) 2+ yrs. mos. ds.

CONTRIBUTORY (Secondary): Myoma uteri

(duration) 8 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 7-5-29

Was there an autopsy? yes.

What test confirmed diagnosis? --

(Signed) R. Gordon Douglas M. D.

, 19 (Address) J. H. H.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: M. E. Cedars — DATE OF BURIAL: 7-7-29

20 UNDERTAKER: Daniel Jenkins — ADDRESS: 516 [illegible]

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47417

1-001

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals

REGISTERED No. E 47417

CITY OF BALTIMORE: (No. ?? ST. 17-19 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Virginia Butler (Butler)

(a) RESIDENCE NO. 403 McAlester ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of ?? Richard Butler

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... or ... min.
	26			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laundress

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Gloucester Co.
(State or country) Virginia

PARENTS

10 NAME OF FATHER Guy Brooks

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) Virginia

12 MAIDEN NAME OF MOTHER Alice ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) Virginia

14 Informant Records of
(Address) Balto. City Hospitals

15 Filed JUL 7 1929 JAMES H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 27, 19 29, to July 2, 19 29, that I last saw her alive on July 2, 19 29 and that death occurred, on the date stated above, at 9:25 A. M.

The CAUSE OF DEATH* was as follows:

Typhoid fever

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Phys. Exam. Autopsy

(Signed) [illegible], M. D.

7-3, 19 29 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Gloucester Co. Va	July 5 19 29
20 UNDERTAKER	ADDRESS
Mrs. B. G. Elliott	1425 Argyle Ave

Spec.—2-29-28—L. F. S.—500 Bks.

E 47418 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

89 E 47418

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 527 E.41st St. ST., 9-47 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lida B.Cooper,

(a) RESIDENCE NO. 527 E.41st St. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of James H.Cooper,

6 DATE OF BIRTH (month, day, and year) July 12.1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	11	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Co.Md.

PARENTS

10 NAME OF FATHER Conrad Turnbaugh,

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Co.Md.

12 MAIDEN NAME OF MOTHER Isabella Mc Clelland.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore City Md.

14 Informant James H Cooper
(Address) 527 E 41st St

15 Filed 7-1929 H. A. MC CONKEY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year)

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1929, to July 6, 1929, that I last saw h[illegible] alive on July 6, 1929, and that death occurred, on the date stated above, at 4.20 P m.

The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual Symptoms

(Signed) Wm. C. Pillsbury M. D.

(Address) 415 Cedar Croft Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet — DATE OF BURIAL 19

20 UNDERTAKER Geo W Settle — ADDRESS

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47419 — 31 ✓

CERTIFICATE OF DEATH

E 47419

1—PLACE OF DEATH — REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3621 Park Heights Ave. 15-56 WARD)

2—FULL NAME Philip J. Bernstein

(a) RESIDENCE NO. 3621 Park Heights Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Caroline H. Bernstein

6 DATE OF BIRTH (month, day, and year) July 4, 1874

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	-	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Superintendent

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer I.O.F. Temple

9 BIRTHPLACE (city or town) New York City
(State or country) New York

PARENTS

10 NAME OF FATHER Louis Bernstein

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Switzerland

12 MAIDEN NAME OF MOTHER (UNknown) Elkridge

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) England

14 Informant Mr. Samuel G. Bernstein
(Address) 1945 W. Mulberry St.

15 Filed 7-1929 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1926, to July 5, 1929, that I last saw him alive on July 5, 1929, and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

1 Pulmonary Tuberculosis
(two) Toxic Failure, Due to the Pulmonary Tuberculosis

(duration) 4 yrs. mos. ds.

CONTRIBUTORY (Secondary) Laryngeal Tuberculosis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Bernard J. Finch, M. D.

7/8, 1929 (Address) 1707 Edmondson Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery — DATE OF BURIAL July 8 19 29

20 UNDERTAKER Joseph B Cook — ADDRESS 1003 West Baltimore St.

Spec.—1-10-21—M&T—1500 Bks.

E 47420 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

60- E 47420

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hospital (St.) 6-9 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Duartz

(a) RESIDENCE No. 1913 Jefferson St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? 30 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Louis Duarte

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE — Years: 52 — Months: — — Days: — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Child Silver

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Rachael —

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Russia

14 Informant: Rebecca Duarte

(Address) 1913 Jefferson St

15 Filed 7-1929 HAMILTON JOHNS, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7/7 1929

17 I HEREBY CERTIFY, That I attended deceased from 6/12, 1929, to 7/7, 1929, that I last saw her alive on 7/7, 1929, and that death occurred, on the date stated above, at 5:30 A.m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Failure

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Thyrotoxicosis (duration) about 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Basal Metabolism; Clinical

(Signed) B J Cohen M. D.

7/7, 1929 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL/CREMATION/REMOVAL: Hebrew Memorial DATE OF BURIAL: July 7 1929

20 UNDERTAKER: Jack Lewis ADDRESS 1439 E Balto St

TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47421

74-001

E 47421

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 5505 Sefton Ave St., 47-53 Ward)

2-FULL NAME Elizabeth Schnabel

(a) RESIDENCE NO. 5505 Sefton Ave St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Late August F. Schnabel

6 DATE OF BIRTH (month, day, and year) April 9/1844

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	85	2	25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Frankfort
(State or country) Germany

PARENTS

10 NAME OF FATHER John Geo. Meinschel

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Gertrude Mueller

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant August P. Schnabel
(Address) 5505 Sefton Ave

15 Filed JUL 7 1929 H. HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature] M. D.

7/6/29 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Paul Cem. DATE OF BURIAL 7/8 1929

20 UNDERTAKER Philip Herring ADDRESS 516 Aliceanna St

Important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Blks.

E 47422 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 47422

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 104 St. Dunstans Road ST. 27-48 WARD

2-FULL NAME James Ward Allison

(a) RESIDENCE NO. 104 St. Dunstans Road ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. -- mos. -- ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND (or) WIFE of Beatryx Steinacker

6 DATE OF BIRTH (month, day, and year) May 17, 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	53	1	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Freight

(b) General nature of industry, business, or establishment in which employed (or employer): Traffic Manager

(c) Name of employer: Western Md. Railroad

9 BIRTHPLACE (city or town) (State or country): Ohio

PARENTS

10 NAME OF FATHER Abner Allison

11 BIRTHPLACE OF FATHER (city or town) (State or country): Niles Ohio

12 MAIDEN NAME OF MOTHER Sarah Battles

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Niles Ohio

14 Informant: Mrs. Beatryx S. Allison

(Address) 104 St. Dunstans Road

15 Filed 7-1929 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5th 1929

17 I HEREBY CERTIFY, That I attended deceased from July 5th, 1927, to July 5th, 1929, that I last saw h[illegible] alive on 9.45 A.M., 7/5/29 and that death occurred, on the date stated above, at 10.20 A.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage due to Arteriosclerosis Nephritis

(duration) Unknown ds.

CONTRIBUTORY (Secondary) Chronic Endocarditis (duration) Unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of ?

Was there an autopsy? No

What test confirmed diagnosis? ?

(Signed) Effie Buck, M. D.

7/2, 1929 (Address) 110 S. Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge — DATE OF BURIAL 7/8 19 29

20 UNDERTAKER Henry U. Meades Son — ADDRESS 805 N. Calvert

ATION is very important! See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47423

CERTIFICATE OF DEATH

129

E 47423

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4913 Reisterstown Rd STREET) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary C. Harman

(a) RESIDENCE NO. 4913 Reisterstown Rd STREET WARD
(Usual place of abode)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Widowed

6 DATE OF BIRTH (month, day, and year) Nov. 11, 1839

7 AGE	Years	Months	Days	If LESS than 1 day ___ hrs. or ___ min.
90	years	7	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) unknown

PARENTS

10 NAME OF FATHER Henry Summers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) not known

14 Informant Mrs Sara Earl

(Address) 4913 Reisterstown Rd

15 Filed 7-1929, 19 H. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-5-1929

17 I HEREBY CERTIFY, That I attended deceased from 6-5, 1929, to 6-27, 1929, that I last saw her alive on 6-27, 1929, and that death occurred, on the date stated above, at 3. P. m.

The CAUSE OF DEATH* was as follows:

Parenchymatous nephritis Chronic

(duration) 1-2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Auricular fibrillation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Last illness

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Oscar Russell M. D.

7-6, 1929 (Address) 3902 Groveland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Laders Cem. Baltic	July 8 1929
20 UNDERTAKER	ADDRESS
John Burns Sons	Towson

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47424

E 47424

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3119 Gwynn Fall [redacted] WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alecis B. Marcil

(a) RESIDENCE NO. 3119 Gwynn Fall Parkway ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if foreign birth? 65 yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah J. Marcil

6 DATE OF BIRTH (month, day, and year) May 29. 1848

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocer Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Montreal Canada

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Known

12 MAIDEN NAME OF MOTHER Not Known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Known

14 Informant Mrs John A Sotten

(Address) 3119 Gwynn Fall Parkway

15 Filed 7-1929, 19 [illegible] Registrar

(C) HARRISON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6. 1929

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1929, to July 6, 1929, that I last saw h[illegible] alive on July 6, 1929 and that death occurred, on the date stated above, at 4 30 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) [illegible] yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

July 7. 1929 (Address) 2711 Eutaw [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Henton Center Mass.

DATE OF BURIAL July 9 1929

20 UNDERTAKER H. Sander & Sons Inc

ADDRESS 124 Fleet St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47425

CERTIFICATE OF DEATH

59-002

159 E 47425

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE; (No. 2935 Dillon ST., 11 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Leona. Waclawska.

(a) RESIDENCE NO. 2935 Dillon ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6 DATE OF BIRTH (month, day, and year): May 16-1929

7 AGE — Years: — Months: 1 — Days: 20 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Infant.

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto, md.

PARENTS

10 NAME OF FATHER: John Waclawski

11 BIRTHPLACE OF FATHER (city or town) (State or country): Poland.

12 MAIDEN NAME OF MOTHER: Magdalena Zinal

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Poland.

11 Informant: Magdalena Waclawska

(Address) 2935 Dillon St.

Filed JUL 7 - 1929

HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 6-29

17 I HEREBY CERTIFY, That I attended deceased from June 26, 1929, to July 6, 1929, that I last saw h[illegible] alive on July 6, 1929, and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Congenital Heart Trouble

(duration) yrs. 1 mos. 20 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

Signed: [signature] M. D.

19 [illegible], 19[illegible] Address [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislaus Cem.

DATE OF BURIAL: 7/8 1929.

20 UNDERTAKER: Georga A. Weber

ADDRESS 705 S Ann

Cor.—10-10-29—A Co.—100 Bks.

47426

HEALTH DEPARTMENT—CITY OF BALTIMORE

32 E 47426

CERTIFICATE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 7 E-York St. St. 22-6 Ward)

2-FULL NAME Thomas Stepanuk.Jr.

(a) RESIDENCE NO. 7 E.York St. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. 0 mos. 28 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) June 13, 1926

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	8	0	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Thomas Stepanuk.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland.

12 MAIDEN NAME OF MOTHER Anna Parezuk.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland.

14 Informant Anna Stepanuk.(mother)
(Address) 7 E.York St.

Filed JUL 7 - 1929 By HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Tubercular Meningitis.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Inquiry

(Signed) Otto H. Feinhardt M. D.

7/6, 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Ad Co.	July 8 1929
20 UNDERTAKER	ADDRESS
George A. Weber	715-S Ann

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Hks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47427
1-PLACE OF DEATH

CERTIFICATE OF DEATH.

188-103

E 47427
REGISTERED NO.

City of BALTIMORE: (No. Union Memorial Hospital 13-52 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Helen R. Shaffer

(a) RESIDENCE NO. 3643 Elm Ave. St. I3 Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred I9 yrs. 5 mos. I0 How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) January 25, I9I0.

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	I9	5	I0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stenographer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Poole Eng. & Mch. Co.

9 BIRTHPLACE (city or town)

(State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Paul Shaffer

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Mary E. Yealy

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Mt. Rock, Penna.

14 Informant Mrs. Mary E. Shaffer

(Address) 3643 Elm Ave.

Filed JUL 7 - 1929 W. HAMPSON JONES, M. D. Registrar.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 1929.

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture Femurs - due to injuries received by being run over by truck which was backing up to load scrap iron. Was run over by rear wheels

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

Rupt. Bladder (duration) yrs. mos. ds.

(Signed) J. Frame (Coroner) M. D.

6.19 (Address) 29 39 W Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death? Greenspring & Smith Ave.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Date of Burial July 8 1929

20 UNDERTAKER Horace A. Burgee ADDRESS 3631 Falls Rd.

Very important. See instructions on back of certificate. Exact statement of OCCUPATION is

Spec. 2-29-28 L. & S. 500 Blks.

E 47428

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47428

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 47

CITY OF BALTIMORE: (No. 1524 N. Appleton St. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Deborah GORBAN

(a) RESIDENCE NO. 1524 N. Appleton ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Gorban

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 56 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Jack Gorban

(Address) 1524 N. Appleton St

15 Filed 7-7-1929 G. HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 6/29

17 I HEREBY CERTIFY, That I attended deceased from July-5, 1929, to July-6-, 1929 that I last saw h[illegible] alive on July-6-, 1929 and that death occurred, on the date stated above, at 9 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Breast

(duration) One yrs. 7 mos. ds.

CONTRIBUTORY (Secondary): none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) Herman Seidel, M. D.

7/7, 1929 (Address) 2404 Eutaw pl

*State the Disease Causing Death, or In deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lehren Rosedale — DATE OF BURIAL: July 7 19 29

20 UNDERTAKER: D Jack Lewis — ADDRESS: 1439 E Balto St

Spec.—2-29-28—L. F. S.—500 Bks.

E 47429

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

135 V

E 47429

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. St. Joseph Hospital St., 7-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James Fredl (Fridl)

(a) RESIDENCE NO. 1706 Collington Ave. WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rose Fridl

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	56			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER Joseph Fridl

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Rose Fridl

(Address) 1706 Collington

15 Filed JUL 7 - 1929 Registrar

E. HARRISON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/6/29

17 I HEREBY CERTIFY, That I attended deceased from 7/1/29, 19..., to 7/6/29, 19..., that I last saw him alive on 7/6/29, 19..., and that death occurred, on the date stated above, at 3:30 P. m.

The CAUSE OF DEATH was as follows:

hypertrophied prostate

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) uremia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 7/4/29

Was there an autopsy? No What test confirmed diagnosis? clinical course

(Signed) A B Hendrix, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Oakhill	July 9 19 29

20 UNDERTAKER Smart Brockton

ADDRESS 1906 E. Monument

Cor.—10-10-29—A Co.—100 Bks.

E 47430

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47430

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St Jos Hosp St. 9-17 Ward)

2-FULL NAME Angelina Guarantino

(a) RESIDENCE NO. 100 2nd St Brooklyn NY St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F	W	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Pasquala Guarantino

6 DATE OF BIRTH (month, day, and year) Dec 1904

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	25			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) Domestic
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Italy

PARENTS

10 NAME OF FATHER Jno Antonelli

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Italy

12 MAIDEN NAME OF MOTHER Concetta Scacotelli

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Italy

14 Informant Husband - Pasquala Guarantino
(Address) 100 2nd St Brooklyn NY

15 Filed JUL 7 - 1929 C. HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/7 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis - due to an auto accident - auto in which she was riding overturned and crushed woman

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Belair Rd Balto Co

Did an operation precede death? no Date of (nature of operation)

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. H. Frank M. D.

7/7, 1929 (Address) 2939 Mc Elderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New York DATE OF BURIAL 7/7 1929

UNDERTAKER Frank V. Spitone ADDRESS 2718 E Baltimore St

IF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

22 6 8 79

E 47431

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 47431
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rice, Virginia

(a) RESIDENCE NO. Westminster Md ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. 4 ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 COLOR OR RACE: White
5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thomas W. Rice

6 DATE OF BIRTH (month, day, and year): 4/14/02

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
27	2	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School Teacher

(b) General nature of industry, business, or establishment in which employed (or employer): 068

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): md

PARENTS

10 NAME OF FATHER: James Trayer

11 BIRTHPLACE OF FATHER (city or town) (State or country): md

12 MAIDEN NAME OF MOTHER: Delia Ensor

13 BIRTHPLACE OF MOTHER (city or town) (State or country): md

14 Informant: Records
(Address) JOHNS HOPKINS HOSPITAL

15 Filed 8-1929 C. HAMILTON JONES, M. D. Registrar
By R M C

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 8 1929

17 I HEREBY CERTIFY, That I attended deceased from July 4 1929 to July 8 1929 that I last saw h[er] alive on July 8 1929 and that death occurred, on the date stated above, at 8 00 a.m.

The CAUSE OF DEATH* was as follows:

Brain tumor, benign

(duration) 1 yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? Yes Date of July 6, 1929

Was there an autopsy? Yes Removal of tumor

What test confirmed diagnosis?

(Signed) I. Ridgeway Trimble M. D.

July 8, 29 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Westminster — DATE OF BURIAL: July 11 1929

20 UNDERTAKER: H Bankard & Son — ADDRESS: Westminster

TION is very important. See instructions on back of certificates.

Spec.—1-10-21 M&T 1500 Bks.

E 47432 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 47432

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2400 Annah Ave ST. 16-68 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Herman Louis Piel

(a) RESIDENCE No. 2400 Annah Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	widowed.

5a If married, widowed, or divorced HUSBAND of ~~(or)~~ WIFE of Caroline E. Piel

6 DATE OF BIRTH (month, day, and year) June 17. -1850

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
	79	5	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work ... old

(b) General nature of industry, business, or establishment in which employed (or employer) Retired

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Co., Md.

PARENTS

10 NAME OF FATHER John F. Piel

11 BIRTHPLACE OF FATHER (city or town) (State or country) — Germany.

12 MAIDEN NAME OF MOTHER Anna Dattman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) — Germany

14 Informant John F. Piel

(Address) 2400 annah ave.

15 Filed JUL 8 - 1929 SAMSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4 - 1929.

17 I HEREBY CERTIFY, That I attended deceased from July 2 - 1929, to July 5 - 1929.

that I last saw h alive on July 4 1929.

and that death occurred, on the date stated above, at 11:28 a. m.

The CAUSE OF DEATH* was as follows:

Influenza.

(duration) — yrs. — mos 4 ds.

CONTRIBUTORY (Secondary) Organic Heart Disease

(duration) Unknown mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Chester Riland, M. D.

7-5-1929 (Address) 2532 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loraine Park Cemetery DATE OF BURIAL 7/8/1929

20 UNDERTAKER Geo. Weber & Son ADDRESS 2503 Edmondson

TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47433

CERTIFICATE OF DEATH

90

E 47433

1-PLACE OF DEATH Fish Market, Market Space. 12-50

City of Baltimore: (No. ..... St. ..... Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ross P. Campbell.

(a) RESIDENCE NO. 2406 N. Calvert St. St., ... Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 44 yrs. ~~mos.~~ ~~ds.~~ How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married.

5a If married, ~~widowed or divorced~~ HUSBAND of (or ~~WIFE of~~) Blanche Campbell.

6 DATE OF BIRTH (month, day, and year) October 2, ~~1860~~ 1882 Bap

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
Bap. 46	~~46~~	9	3	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Salesman, 46
(b) General nature of industry, business, or establishment in which employed (or employer) Sea food business.
(c) Name of employer

9 BIRTHPLACE (city or town) Zanesville, Ohio.
(State or country)

PARENTS

10 NAME OF FATHER Thomas Campbell.

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) England.

12 MAIDEN NAME OF MOTHER Emma L. Mehrheim.

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Baltimore, Md.

14 Informant Blanche Campbell. (wife)
(Address) 2406 N. Calvert St.

15 Filed ..... C. HAMPSON JONES, M. D.
Registrar

L 8 - 1929 By .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency.
Acute dilatation of the Heart.

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY .....
(Secondary)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? .....

Did an operation precede death? No. Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto Reinhardt, M. D.

7/6, 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge — DATE OF BURIAL 7/8/1929

20 UNDERTAKER Geo. Weber & Son — ADDRESS 2503 Edmond

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47434

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47434 REGISTERED NO.

1—PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. ..... ST. 21-24 90 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harry Evatt

(a) RESIDENCE NO. 835 W. Barre ST., ... WARD
(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? ... yrs. ... mos. ... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year) May 12-1881 Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	48	1	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Elevator Operator

(b) General nature of industry, business, or establishment in which employed (or employer): ? 086

(c) Name of employer: ?

9 BIRTHPLACE (city or town) (State or country): ? Maryland

PARENTS

10 NAME OF FATHER Harry C. Evatt

11 BIRTHPLACE OF FATHER (city or town) (State or country): ? Maryland

12 MAIDEN NAME OF MOTHER Vtrginia Johnson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ? Virginia

14 Informant: Records of

(Address) Baltimore City Hospitals

15 Filed ... 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 4, 1929, to July 6, 1929, that I last saw him alive on July 6, 1929 and that death occurred, on the date stated above, at 4:20 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic Acute
Myocardial Insufficiency
Aortic " ?

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Marvin H. McLean, M. D.

7-6, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon County

DATE OF BURIAL 7/9 1929

20 UNDERTAKER W. W. Cook

ADDRESS 1211 St. Paul

Spec.—1-10-21—M&T—1500 Bks.

226688 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47435

CERTIFICATE OF DEATH.

E 47435

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL St. 21-29 WARD)

2-FULL NAME Peter Griffith

(a) RESIDENCE No. 321 Scott St., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? Unknown yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Unknown

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer) odd jobs irregular

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) England

PARENTS

10 NAME OF FATHER Robert Griffith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Europe

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant (Address) Records JOHNS HOPKINS HOSPITAL

15 Filed JUL 8 1929 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 1929

17 I HEREBY CERTIFY, That I attended deceased from June 4, 1929, to July 6, 1929, that I last saw him alive on July 6, 1929, and that death occurred, on the date stated above, at 130 A m.

The CAUSE OF DEATH* was as follows:

Appendicitis

Myocarditis -

CONTRIBUTORY (Secondary) Broncho-pneumonia (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? (duration) yrs. mos. ds.

Did an operation precede death? Yes Date of June 27 1929

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) George E. Finney M. D.

July 6 1929 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cemetery

DATE OF BURIAL 7/9 1929

20 UNDERTAKER Wm Cook

ADDRESS 1217 E Pratt

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47436 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129

REGISTERED NO. E 47436

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 619 West Frank (St.) (WARD)

2—FULL NAME Katherine Stidman

(a) RESIDENCE NO. 619 West Franklin St. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

a If married, widowed, or divorced
HUSBAND) of
(or) WIFE of George W.

6 DATE OF BIRTH (month, day, and year) ~~Feb~~ 12/8/50

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	4	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Albert E Stidman

(Address) 619 West Franklin

15 Filed 7-8 19 29 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 — 29.

17 I HEREBY CERTIFY, That I attended deceased from Jan. 3d, 19 29, to July 6th, 19 29, that I last saw h[illegible] alive on June 28, 19 29 and that death occurred, on the date stated above, at 6:15 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis
& Mitral Regurgitation

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual

(Signed) Elbert C. Rietz, M. D.

7/6, 1929 (Address) 711 St. Paul St. Baltimore

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Grace Church Edridge — DATE OF BURIAL 7/8 19 29

20 UNDERTAKER W. J. Cook — ADDRESS 1217 St Paul

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47437

CERTIFICATE OF DEATH

REGISTERED NO. **E 47437**

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 775 Washington ST., 21 WARD)

2—FULL NAME Mary L Schuler.

(a) RESIDENCE NO. 775 Washington Blvd ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 52 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow.

a If married, widowed, or divorced (HUSBAND of) (or) WIFE of Wm F Schuler

6 DATE OF BIRTH (month, day, and year) Aug 13-1862

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	66.	10	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER James H Conway

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Higgins

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Howard Schuler

(Address) 775 Washington Blvd

15 Filed JUL 8 1929 H. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 8, 1929 to July 6 1929 — that I last saw her alive on July 6, 1929 — and that death occurred, on the date stated above, at 2:30 p m.

The CAUSE OF DEATH* was as follows:

Carcinoma of right breast with general metastisis.

generalized carcinomatosis.

(duration) 1 yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) cardiac insufficiency.

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of May 31, 1928

Was there an autopsy? No —

What test confirmed diagnosis? usual tests.

(Signed) George A. Krupp. M. D.

19 (Address) 3030 Edmondson Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Pk — DATE OF BURIAL July 8 29

20 UNDERTAKER Wm Cook — ADDRESS 1111 St Paul St

Spec.—2-29-28—L. F. S.—500 Bks.

E 47438 HEALTH DEPARTMENT—CITY OF BALTIMORE 90a E 47438

CERTIFICATE OF DEATH

1—PLACE OF DEATH 5903 Arabia Ave. REGISTERED NO. 27-43

CITY OF BALTIMORE: (No.) (ST.) (WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William H. Hoyde

(a) RESIDENCE NO. 5903 Arabia ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M.

4 COLOR OR RACE: W

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Widower

6a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~: Chrissey Hoyde

6 DATE OF BIRTH (month, day, and year): Feb. 21 1861

7 AGE: Years 67 | Months 4 | Days 14 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Pay Clerk
(b) General nature of industry, business, or establishment in which employed (or employer): Railway Express
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Riff Hoyde

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Mary Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Fannie Haywood
(Address) 5903 Arabia Ave

15 Filed 1929 E. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 5-1929

17 I HEREBY CERTIFY, That I attended deceased from June 16 1929 to July 5 1929 that I last saw h~~im~~ alive on July 4 1929 and that death occurred, on the date stated above, at 6 30 a m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis several years
CONTRIBUTORY (Secondary) Arteriosclerosis many years.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Morris B. Green M. D.

7/7 1929 (Address) Hamilton Baltimore Md

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Carlwood — DATE OF BURIAL: 7/8 1929

20 UNDERTAKER: Wm Cook — ADDRESS: 12 17 St Paul St

ULS - 1929

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47439

CERTIFICATE OF DEATH.

E 47439

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Baltimore City Hospt. St., 16-37 Ward)

2-FULL NAME Edward Fitzpatrick

(a) RESIDENCE NO. Martel & West Aves Colgate Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 10 1923

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	6	0	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Edward A Fitzpatrick

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Leona L. Lang

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore Md

14 Informant Leona L. Fitzpatrick

(Address) Martel & West Aves Colgate

15 Filed JUL 8 - 1929, H. HANSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry.) find that said deceased came to ~~—~~ death on the day stated above.

The CAUSE OF DEATH* was as follows: Fractured Skull - due to running into truck driven by Howard Kuss - accidental death Instantly

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Central Concussion

(duration) yrs. mos. ds.

7/6, 1929 (Signed) L. Frank M. D. (Coroner) (Address) 2939 Mc Elderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death ....yrs. ....mos. ....ds. In the State ....yrs. ....mos. ....ds.

Where was disease contracted, if not at place of death? Bath St Rd. Balto Co.

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Sacred Heart of Mary Date of Burial July 8 1929

20 UNDERTAKER John M Weber ADDRESS 701 S Chester

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Blks.

E 47440

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47440
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 508 S Bradford St., 1-3 Ward)

2-FULL NAME John Conrad

(a) RESIDENCE NO. 508 S Bradford St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug. 6 1916

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	12	10	23	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Adam Conrad

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore

12 MAIDEN NAME OF MOTHER Eleanora Reynolds

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore

14 Informant Adam Conrad
(Address) 508 S. Bradford

Filed JUL 8 - 1929 HARRY JONES, M. D. Registrar

Par

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:
Enteric Colitis

(duration) yrs. mos. 1 ds.
CONTRIBUTORY (Secondary) (Pneumonia)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 3514 O'Donnell
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) James M Kenton, M. D.
19 29 (Address) 705 E Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem	9 1929
20 UNDERTAKER	ADDRESS
John M Wilber	Old Chester

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47441

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

57 E 47441

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 705 S. Bond St. ST. 2-4 WARD)

2—FULL NAME Frank Pelachawski

(a) RESIDENCE NO. 705 S. Bond St. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 10 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	8	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 0 10

(b) General nature of industry, business, or establishment in which employed (or employer) Labor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Elezabeth Pelachawski

(Address) 705 S. Bond St.

15 Filed JUL 8 1929 C. HANSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5 1929

17 I HEREBY CERTIFY, That I attended deceased from June 28, 19 29, to July 5, 19 29, that I last saw him alive on July 5, 19 29, and that death occurred, on the date stated above, at 12 15 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage —

(duration) yrs. mos. 6 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) W. S. Elmy, M. D.

7/7, 1929 (Address) 622 W Read Av.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary Cem	July 9 1929
20 UNDERTAKER	ADDRESS
John A Weber	402 A Chestnut

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47442

CERTIFICATE OF DEATH

167-001

E 47442

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1945 W Pratt St. 30-28 Ward)

2-FULL NAME Andrew Gries

(a) RESIDENCE NO. 1945 W Pratt St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sophia M. Gries

6 DATE OF BIRTH (month, day and year) Oct. 6. 1884

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	44	8	29	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Merchant (Tailor)
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto Md

PARENTS

10 NAME OF FATHER Andrew Gries

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs Sophia M Gries
(Address) 1945 W Pratt

15 Filed ..., G. HAMPSON JONES, M. D., Registrar

L 8 - 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to h... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Supposed by Gas (Illuminating)

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Chas. W. Browne, M. D.

July 5. 1929 (Address) 3601 [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	July 8 1929

20 UNDERTAKER George L. Schwab ADDRESS 1101 Fulton Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47443

CERTIFICATE OF DEATH

90

E 47443

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 6 Baltimore City Hospitals ST. 4-28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Edward Smith

(a) RESIDENCE NO. 1608 W. Pratt st. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	49			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Potter

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Jacob Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Liza Anne Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Records
(Address)

15 Filed 8-1929 C. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 18, 1929, to July 5, 1929,

that I last saw him alive on July 5, 1929

and that death occurred, on the date stated above, at 1.20 A. m.

The CAUSE OF DEATH* was as follows:

Mitral stenosis
Cardiac hypertrophy
Cardiac failure

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical and autopsy

(Signed) Henry C. Smith M. D.

7-5-1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	July 8 1929
20 UNDERTAKER	ADDRESS
George L. Schwab	3rd Fiedk Ave.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47444

CERTIFICATE OF DEATH.

129

E 47444

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2717 Bernard St. 12-51 WARD)

2-FULL NAME Elsie L. Daniels

(a) RESIDENCE No. 2717 Bernard ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or Divorced, (write the word): Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Joseph Daniels

6 DATE OF BIRTH (month, day, and year): March 21/1896.

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min
33.	3.	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: at home

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Ambrose E. Phillips

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland.

12 MAIDEN NAME OF MOTHER: Florence R. Barnes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland.

14 Informant: Mrs. Mabel DeLane

(Address) 2717 Bernard St.

Filed JUL 8 1929, 19

HAMILTON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 6/1929.

17

I HEREBY CERTIFY, That I attended deceased from 7/1/29 to 7/6/29, 19

that I last saw her alive on 7/6/29, 19

and that death occurred, on the date stated above, at 335 P. m.

The CAUSE OF DEATH* was as follows:

Cl Diph. Tx.

Hemorrhage

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) Edward J. Fenny, M. D.

7/8/1929 (Address) 9 W Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Cem. Hampden — DATE OF BURIAL: July 9 1929

20 UNDERTAKER: J. Walter Davis — ADDRESS: 330 Park St

TION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47445

CERTIFICATE OF DEATH

E 47445

1—PLACE OF DEATH

REGISTERED NO. 46-67 117

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Md General Hospital ST., WARD)

2—FULL NAME James B. Marlow

(a) RESIDENCE NO. 312 Baker ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 5, 1905

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	24	3	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer) 066

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER J. Edwin Marlow

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Emma Hafer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Hospital Records
(Address)

15 Filed 8-15-29 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/6/29

17 I HEREBY CERTIFY, That I attended deceased from June 7, 19 29, to July 6, 19 29
that I last saw him alive on July 6, 19 29
and that death occurred, on the date stated above, at 7 30 P m.

The CAUSE OF DEATH* was as follows:

Chronic appendicitis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Amebiasis (duration) yrs. mos. 20 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? Yes Date of 6/8 & 7/29

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jno. B. Templeman, M. D.

(Address) 1715 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine Cemy.	July 9, 1929
20 UNDERTAKER	ADDRESS
John O. Mitchell & Sons	1900 Eutaw

Spec.—2-29-28—L. F. S.—500 Bks.

E 47446

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

49 E 47446

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2431 Edmondson Ave. ST. 20-69 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Catharine Hays Griffith

(a) RESIDENCE NO. 2431 Edmondson Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
female	white	widowed

.a If married, widowed, or divorced
HUSBAND of
(or) WIFE of James Henry Griffith

6 DATE OF BIRTH (month, day, and year) Sept. 14, 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	74	9	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md.

PARENTS

10 NAME OF FATHER James Armstrong Hays

11 BIRTHPLACE OF FATHER (city or town) Balto.
(State or country) Md.

12 MAIDEN NAME OF MOTHER Catharine Jane Armstrong

13 BIRTHPLACE OF MOTHER (city or town) Balto.
(State or country) Md.

11 Informant Miss Alice Griffith
(Address) 2431 Edmondson Ave.

15 FILED JUL 8 - 1929 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5 1929.

17

I HEREBY CERTIFY, That I attended deceased from June 17, 1929, to July 5, 1929, that I last saw h alive on July 5, 1929 and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Thyroid Gland

CONTRIBUTORY (Secondary) (duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home (duration) yrs. 3 mos. ds.

Did an operation precede death? yes Date of April 1929

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) John T Evans, M. D.

1929 (Address) 612 N 40 st.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cemetery — DATE OF BURIAL July 8, 1929

20 UNDERTAKER John O. Mitchell & Sons, Madelon B. Mitchell — ADDRESS 1900 Eutaw Place

Cor.—10-10-29—A Co.—100 Bks.

Schmidt

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47447

CERTIFICATE OF DEATH

123 E 47447

1-PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

City of Baltimore: (No. Church Home & Infirmary St., 26-42 Ward)

2-FULL NAME Mrs. Sophie Schmidt

(a) RESIDENCE NO. 4301 Wiltshire Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Schmidt

6 DATE OF BIRTH (month, day, and year) Aug 16/1869

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	59	11	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At Home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto., Md.
(State or country)

PARENTS

10 NAME OF FATHER Herman Schulte

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany

12 MAIDEN NAME OF MOTHER Wilhemina Kramer

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Miss Elizabeth Poetter
(Address) 4301 Wiltshire Ave

15 Filed ..... 19.. H. HARRISON JONES, M. D., Registrar

JL 6 - 1929 1600

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 5/29

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cholelithiasis & Cholangitis

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Dilitation

(duration) 1p min yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) [signature], M. D.

7/6/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem — DATE OF BURIAL July 8 1929

20 UNDERTAKER [signature] — ADDRESS 2008 Aliceanna

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. - See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47448

CERTIFICATE OF DEATH.

E 47448

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 227 Montford ave ST., 6-16 WARD)

2-FULL NAME David Milligan

(a) RESIDENCE No. 227 Montford ave ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 48 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colord	Widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 10. 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	48	7	26.	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Barber
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER John Milligan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Francis Williams

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Bessie Burrell
(Address) 228 Bradford st

15 Filed JUL 8 - 1929 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 1929

17 I HEREBY CERTIFY, That I attended deceased from April 28, 1929, to July 6, 1929, that I last saw him alive on July 5, 1929, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Throat.
Cardiac Insufficiency

CONTRIBUTORY (Secondary) Myocardial Insufficiency (duration) ..... yrs. 1 mos. 2 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Wm. G. Leyh, M. D.

(Address) 1516 N. Mulberry Ave, Md. 19

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL asbury cemetery — DATE OF BURIAL July 8, 1929

20 UNDERTAKER Edward Bryan — ADDRESS 1631 orleans st

TION is very important See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47449 E 47449

CERTIFICATE OF DEATH

15-65 90

1-PLACE OF DEATH

City of Baltimore: (No. Pronounced dead at Mercy Hospital. (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Louis Crook

(a) RESIDENCE NO. 4019 Bonner Rd. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. ---- mos. ---- ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White.	Widower.

5a If ~~single~~, widowed, ~~or wife of~~ HUSBAND of ~~XXXXXXXXXX~~ Ester Yetta Crook.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	78	--------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Russia-
(State or country)

PARENTS

10 NAME OF FATHER Israel Crook.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia.

12 MAIDEN NAME OF MOTHER Gittel -------

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia.

14 Informant Jack Lewis.
(Address) 1439 E. Baltimore St.

15 Filed ..., 19... HAMILTON JONES, M. D. Registrar

18-1929 100

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Organic disease of the Heart.

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted? Madison Ave car. If not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? Inquiry
(Signed) Otto Hemnarck, M. D.
7/8 . 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Helen Wash Rd — DATE OF BURIAL July 8 1929

20 UNDERTAKER Jack Lewis — ADDRESS 1439 E Balto St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47450

CERTIFICATE OF DEATH

23 E 47450

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1654 E. Pratt St. (ST.) 3-1 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harry J. Lipnick

(a) RESIDENCE NO. 1654 E. Pratt St. (ST.) WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if foreign birth 26 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Tobie Lipnick

6 DATE OF BIRTH (month, day, and year): [illegible]

7 AGE: Years 39; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Cigar Merchant

(b) General nature of industry, business, or establishment in which employed (or employer): [illegible]

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Julius H Lipnick

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Alista

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Tobie Lipnick

(Address) 1654 E. Pratt St

Filed 8-1929

H. LLOYD JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 8 29

17 I HEREBY CERTIFY, That I attended deceased from June 28 . 19 29 . to July 7 . 19 29 .

that I last saw h— alive on July 8 . 19

and that death occurred, on the date stated above, at 12-05 a m.

The CAUSE OF DEATH* was as follows:

Endocarditis Ulcerosa

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary): Acute Edema - Lungs -

(duration) yrs. mos. ½ ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? no Date of ✓

Was there an autopsy? no

What test confirmed diagnosis? ✓

(Signed) Burke Brandt, M. D.

. 19 (Address) 125 C Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Helping Rest — DATE OF BURIAL: 7/8/29

20 UNDERTAKER: Jack Levin — ADDRESS: 1439 E. Baltimore St

Spec.—1-10-21—M&T—1500 Blks.

226799
E 47451

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

+40 E 47451

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 1-9 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Annie Godsey

(a) RESIDENCE No. Walter ave Turner Sta Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred unknown yrs mos. 3 ds. How long in U. S., if of foreign birth? yrs mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Black

5 Single, Married, Widowed, or Divorced, (write the word) Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) 5/11/93

7 AGE 35 Years 36 Months 10 Days 25 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Kirby McGee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Mary Gaines

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed , 19 H. [illegible] JONES, M. Registrar

L 8 - 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 1929

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1929, to July 6, 1929, that I last saw her alive on July 6, 1929, and that death occurred, on the date stated above, at 11.23 Pm.

The CAUSE OF DEATH* was as follows:

Paralytic ileus.
Peritonitis, early

(duration) — yrs. — mos 4 ds.

CONTRIBUTORY (Secondary) Retroperitoneal Abscess (left) duration yrs Unknown ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of 7/3/29

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Raymond F. Jones, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Reisterstown Md DATE OF BURIAL July 8, 1929

UNDERTAKER H. G. Elliott ADDRESS 1125 Ashland Ave

TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

Schmaelzle.

E 47452

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

89

E 47452
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 15.)

1-PLACE OF DEATH

City of Baltimore: (No. 3514 O'Donnell St. 1-1 Ward)

2-FULL NAME John P. Schmaelzle

(a) RESIDENCE NO. 3514 O'Donnell St. Ward
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? 50 yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	White	widower

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Hannah E. Schmaelzle

6 DATE OF BIRTH (month, day, and year) July 29 1864

7 AGE	Years	Months	Days	If LESS than 1 day ... hrs. or ... min.
	64	11	7	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer) Steel Worker
(c) Name of employer Sparrows Pt

9 BIRTHPLACE (city or town) Germany
(State or country)

PARENTS

10 NAME OF FATHER don't know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Germany.

12 MAIDEN NAME OF MOTHER don't know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Germany

14 Informant Mrs. Myrtle Jones
(Address) 3514 O'Donnell St

15 Filed ... 19... C. HAMPSON JONES, M. D. Registrar

L 8 - 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 192 29

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:
Angina Pectoris

(duration) Sudden yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 3514 O'Donnell

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M. Hanlon M. D.

7 E. Chase (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oaklawn Cemetery — DATE OF BURIAL: July 10 1929

20 UNDERTAKER: George W. Zirkler — ADDRESS: 1737 E. Eager St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

Silnick

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47453

CERTIFICATE OF DEATH.

161-001

E 47453

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No.) Stone House Cor. 25-76 St. (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Eva Silnick

(a) Residence No. Stone House Cor 13th & Hagner Ave. St. Ward.

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-Single, Married, Widowed, or Divorced. (Write the word.) Single

6a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July 6-1924

7-AGE. yrs. mos. ds. If LESS than 1 day, 22 hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer).

(c) Name of employer.

9-BIRTHPLACE (city or town) (State or Country). Baltimore

PARENTS.

10-NAME OF FATHER. Peter Silnick

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Balto

12-MAIDEN NAME OF MOTHER. Agnes Hill

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Piedmont Co Va

14- (Informant) Peter Silnick

(Address) Stone House Cor. 13th

15- Filed JUL 8 - 1925. C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 7-1924

17- I HEREBY CERTIFY, That I attended deceased from July 6 1924 to July 7 1924 that I last saw h. alive on July 7 1924 and that death occurred, on the date stated above, at 5.30 p. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(7 months)

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Leon L. Horica M. D.

July 8 1924 (Address) 4700 Pennsylvania

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL/CREMATION OR REMOVAL.	DATE OF BURIAL.
St Stanislaus	July 8 1924

20-UNDERTAKER. John W Webb

ADDRESS Cobb Chester

instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47454

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

46 **E 47454**

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 939 Stilmington Ave ST. 5-7E WARD)

2—FULL NAME Philomena Sheir

(a) RESIDENCE NO. 939 Stilmington Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. — mos. — ds. How long in U. S., if foreign birth — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

a If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of the late Edward Sheir

6 DATE OF BIRTH (month, day, and year) Not known

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	78	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) St. Mary's Co. Md

PARENTS

10 NAME OF FATHER Henry Earwood

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Mrs. Cecelia Finnegan
(Address) 939 Stilmington Ave

15 Filed JUL 8 1929 JAMES H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6th 1929

17 I HEREBY CERTIFY, That I attended deceased from June 27, 1929, to July 6, 1929, that I last saw h[illegible] alive on July 6, 1929 and that death occurred, on the date stated above, at 12.45 P. m.

The CAUSE OF DEATH* was as follows: Carcinomatous Ulcers Chronic Interstitial Nephritis

CONTRIBUTORY (Secondary) Pulmonary Edema (duration) Unknown yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Robert C. Hebb, M. D.

7/8, 1929 (Address) 257 W Ostend Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cemetery — DATE OF BURIAL July 9, 1929

20 UNDERTAKER Henry Hoeck Long Sec. — ADDRESS 1301 E Eager St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47455

CERTIFICATE OF DEATH

56

REGISTERED NO. E 47455

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1207 Upton Street ST., 17-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Irene Lucille Laws

(a) RESIDENCE NO. 1207 Upton St ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of --

6 DATE OF BIRTH (month, day, and year) Dec -17th1928

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
[illegible]	6	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore City

PARENTS

10 NAME OF FATHER Franklin Laws

11 BIRTHPLACE OF FATHER (city or town) (State or country) U. S.

12 MAIDEN NAME OF MOTHER Ella Finney

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore City

14 Informant Ella Laws

(Address) 1207 Upton St

15 Filed JUL 8 1929 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7th-1929

17

I HEREBY CERTIFY, That I attended deceased from June-1st-1929, 19, to July-7th, 1929,

that I last saw her alive on July-6th-1929 19

and that death occurred, on the date stated above, at 7-A. M.

The CAUSE OF DEATH* was as follows:

Ricketts

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Mal -nutrition

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thomas H. Magruder M. D.

, 19 (Address) 14. E. Read St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
M. Auburn Cem	7-8 1929
20 UNDERTAKER Dennis Carter	ADDRESS 916 Eden av

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47456

CERTIFICATE OF DEATH

162

E 47456

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1425 Vincent ST. 15-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Girl Day

(a) RESIDENCE NO. 1425 Vincent ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence In city or town where death occurred 0 yrs. 0 mos. 13 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 25, 1929

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
0	0	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment In which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Harry Day

11 BIRTHPLACE OF FATHER (city or town) Annapolis (State or country) Md

12 MAIDEN NAME OF MOTHER Margie Brown

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Harry Day (Father)
(Address) 1425 Vincent St

15 Filed [illegible] 19[illegible] HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 25, 1929, to July 8, 1929

that I last saw h alive on July 7, 1929

and that death occurred, on the date stated above, at 4:30 A m.

The CAUSE OF DEATH* was as follows:

Congenital atelectasis

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. Alexander Morey, M. D.

7/8, 1929 (Address) 1516 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	7/8 1929
20 UNDERTAKER	ADDRESS
Edward Toulon	2207 Druid

IMPORTANT: See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47457 (3) E 47457

1—PLACE OF DEATH E 47457 REGISTERED NO.

CITY OF BALTIMORE: (No. 808 Aisquith ST., 7-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Salvatore Buccheri

(a) RESIDENCE NO. 808 Aisquith ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Frances Buccheri

6 DATE OF BIRTH (month, day, and year) Nov 5 1862

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
66	8	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Gaetano Buccheri

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Rosa Di Liberto

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Rosa Collurafici

(Address) 5813 Belair Road

15 Filed JUL 8 1929, 19 H. [illegible] JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 29, 1929, to July 7, 1929, that I last saw him alive on July 7, 1929, and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary tuberculosis

(duration) 0 yrs. 6 mos. 0 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? gram stain

(Signed) Chas. S. Kenstock, M. D.

19 (Address) 1730 Linden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	July 10, 1929
20 UNDERTAKER Grant V. Bibitone	ADDRESS 2818 E. Balto st

L 8 - 1929

Spec.—1-12-23—M&T—500 Bks.

E 47458 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 47458 REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH St. Agnes Hospital

CITY OF BALTIMORE: (No. Wilkens & Caton Aves ST. 25-12 WARD)

2-FULL NAME Charles White

(a) RESIDENCE NO. Relay Md ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	widower

5a If married, widowed, or divorced HUSBAND of or) WIFE of Sarah E. White

6 DATE OF BIRTH (month, day, and year) Feb. 23, 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	4	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER William White

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) United States

14 Informant Daughter - Mrs Nellie Felling (Address) Relay Md

15 Filed JUL 8 - 1929 E. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-7 1929

17 I HEREBY CERTIFY, That I attended deceased from 7-3 .1929. to 7-7 .1929.

that I last saw h-m alive on 7-7 .1929.

and that death occurred, on the date stated above, at 4 40 P m.

The CAUSE OF DEATH* was as follows:

Strangulated Inguinal Hernia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? Yes Date of July 5

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) Nicholas M. Boullin M. D.

7/7 .29 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL July 10 19 29

20 UNDERTAKER

ADDRESS 1003 West Baltimore St

TION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 47459

1-PLACE OF DEATH West Baltimore General 1929 E 47459

REGISTERED NO.

CITY OF BALTIMORE: (No. 15-58 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Michael Schimberg

(a) RESIDENCE NO. 2904 Rockrose Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Deceased

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lunch Room.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Frank Schimberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Anna

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Mr Schimberg

(Address) 2904 Rockrose ave

15 Filed JUL 8 - 1929 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1929 to July 7, 1929.

that I last saw him alive on July 7, 1929

and that death occurred, on the date stated above, at 8:55 P. m

The CAUSE OF DEATH* was as follows:

Chronic Nephritis.

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic Myocarditis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Clinical

(Signed) J. Mastagna, M.D.

7/7/29 (Address) West Balto General.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Hebrew Cemetery

DATE OF BURIAL July 9 1929

UNDERTAKER S. Levinson Bro

ADDRESS 1127 E Balto St

TION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47460

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 47460

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 834 S. Conkling ST. 16-31 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emily Berg.

(a) RESIDENCE NO. 834 S. Conkling ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

a If married, widowed, or divorced HUSBAND of (or) WIFE of late Frank J.

6 DATE OF BIRTH (month, day, and year) 1863

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER John J. West

11 BIRTHPLACE OF FATHER (city or town) (State or country) Stockholm

12 MAIDEN NAME OF MOTHER Anna Christine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Stockholm

14 Informant H. Berg (Address) 834 S. Conkling st

15 Filed 7/8, 19 29 Registrar

C. HARRISON JONES, M. D.

L 8 - 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 / 29

17

I HEREBY CERTIFY, That I attended deceased from March 6, 1929, to July 6, 1929, that I last saw h alive on June 6, 1929 and that death occurred, on the date stated above, at 12-45 m.

The CAUSE OF DEATH* was as follows:

a Chronic Duodenal Ulcer

b Acute Dysentery

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Heart failure & Exhaustion

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Signs & Symptoms

(Signed) Harry D Buttolph, M. D.

7/6, 1929 (Address) 1625 E Bute ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cemetery	July 9 1929
20 UNDERTAKER	ADDRESS
S. Levinson & Bro	1127 E. Baltimore st

Spec.—1-12-23—M&T—500 Blks.

47461

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

154-002

E 47461

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 808 S. Eaton ST. 26-27 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Mack Jr.

(a) RESIDENCE NO. 808 S. Eaton ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 6. 1929

7 AGE: Years | Months | Days | If LESS than 1 day, 22 hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) City

PARENTS

10 NAME OF FATHER Charles Mack

11 BIRTHPLACE OF FATHER (city or town) (State or country) City

12 MAIDEN NAME OF MOTHER Mary Stokes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) City.

14 Informant Mary Mack (Mother) (Address) 808 S. Eaton St

15 Filed JUL 8 1929 19 Per [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7/29.

17 I HEREBY CERTIFY, That I attended deceased from July 6 1929, to July 7 1929.

that I last saw him alive on July 7 1929

and that death occurred, on the date stated above, at 3.30 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Malformation Heart.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Gustav C. Theime, M. D.

19 (Address) 16 N. Kenwood Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Pak. Lawn. Cem.

DATE OF BURIAL: July 8, 1929.

20 UNDERTAKER: Wendell & Leppel

ADDRESS: 3004 Colud

TION is very important See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47462

CERTIFICATE OF DEATH.

E 47462

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 700 N. Gilmor ST. 16-22 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Carrie Waters.

(a) RESIDENCE NO. 700 N. Gilmor ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE colored

5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eugene Waters

6 DATE OF BIRTH (month, day, and year) Sept. 15, 1888.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	40	9	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Prince George Co. Md.

PARENTS

10 NAME OF FATHER George Campbell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Prince George Co

12 MAIDEN NAME OF MOTHER Jane Conlon

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Hattie Ford

(Address) 700 N. Gilmor St.

15 Filed July 8 1929 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8 1929.

17 I HEREBY CERTIFY, That I attended deceased from May 28, 1929, to July 8, 1929.

that I last saw h alive on July 7, 1929.

and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

about 3

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Fehling's Sugar Test.

(Signed) C. N. Pilgrim, M. D.

7/8, 1929 (Address) 1536 W. Lanvale St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Bloomingdale

DATE OF BURIAL July 10 1929

UNDERTAKER Florence Talbert

ADDRESS 964 Mary

8 1929

THIS is very important See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47463

CERTIFICATE OF DEATH.

117 E 47463

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Franklin Square Hospital ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mildred B. McGinnis

(a) RESIDENCE No. 1152 Gorsuch Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Edward F. McGinnis

6 DATE OF BIRTH (month, day, and year): April 20-1905

7 AGE: Years 24 Months 2 Days 17 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Wm F. Sherwood

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto md.

12 MAIDEN NAME OF MOTHER: Annie E. Franke

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md.

14 Informant: Edward F. McGinnis (Address) 1152 Gorsuch Ave.

15 Filed JUL 8 1929 19 H. HAMILTON JONES, M. D. Registrar RRK

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 7 1929

17

I HEREBY CERTIFY, That I attended deceased from June 23, 1929, to July 7, 1929.

that I last saw her alive on July 6, 1929.

and that death occurred, on the date stated above, at 12.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic appendicitis

(duration) yrs. mos 18 ds.

CONTRIBUTORY (Secondary): Intestinal obstruction

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of June 24, 1929

Was there an autopsy? No

What test confirmed diagnosis? Operative findings

(Signed) John A. Brubaker, M. D.

19 (Address) 37 S. Stricker St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Parkwood Cemetery — DATE OF BURIAL 7/10 1929

20 UNDERTAKER: Chas. S. Maud & Son — ADDRESS 11 North Royal Ave

Spec.—2-29-28—L. F. S.—500 Bks.

E 47464

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001

E 47464

1—PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO.

CITY OF BALTIMORE: (No. ST 18-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Henry

(a) RESIDENCE NO. 130 N. Carlton ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., If foreign birth? ? yrs. ? mos. ? ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	? 47			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): ? 0 40

(c) Name of employer: ?

9 BIRTHPLACE (city or town) (State or country): Unknown

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): ? Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ? Unknown

14 Informant: Records of

(Address) Balto. City Hospitals

15 Filed JUL 8 - 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 4, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 24, 1929 to July 4, 1929, that I last saw him alive on July 4, 1929 and that death occurred, on the date stated above, at 4:30 A. m.

The CAUSE OF DEATH* was as follows:

Hypertension

Arteriosclerosis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemiparesis (Cerebral Hemorrhage) (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Marvin G. Wilson, M. D.

7-5, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND

DATE OF BURIAL: JUL 8 - 1929

20 UNDERTAKER

ADDRESS

[illegible] Commissioner Health

IMPORTANT: SEE INSTRUCTIONS ON BACK OF CERTIFICATE.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47465 | CERTIFICATE OF DEATH | 129 E 47465

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 26-32 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles J. Murphy

(a) RESIDENCE NO. No Home ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ?yrs. ?mos. ? ds. How long in U. S., if foreign birth? --yrs. --mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of --

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	86			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) ?
(State or country) Kentucky

PARENTS

10 NAME OF FATHER Christopher Philips

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) Kentucky

12 MAIDEN NAME OF MOTHER Sarah DeBarr

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) Indiana

14 Informant Records of

(Address) Baltimore City Hospitals

Filed JUL 3 - 1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1928, to July 3, 1929, that I last saw him alive on July 3, 1929 and that death occurred, on the date stated above, at 2:45 A.M.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis (undetermined)

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis? Post Mortem

(Signed) Harvey [illegible], M. D.

7-3, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL UNIVERSITY OF MARYLAND — DATE OF BURIAL JUL 8 - 1929

20 UNDERTAKER — ADDRESS

Commissioner Health.

Important: See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 47466

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

Dr McInnes
Lt. Rolandt

170 E 47466

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Union Memorial Hospital St. 348 Ward 8)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Matthew Hunn

(a) RESIDENCE NO. 428 Evesham Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 Color or Race White

5 Single, Married, Widowed, or Divorced. (write the word) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Hunn

6 DATE OF BIRTH (month, day, and year) April 22-1904

7 AGE Years 25 Months 2 Days 9 IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Warehouse Man

(b) General nature of industry, business, or establishment in which employed (or employer) Harris Bottling Co.

(c) Name of employer

9 BIRTHPLACE (city or town) Hilton

(State or country) N.Y.

PARENTS

10 NAME OF FATHER Frank Hunn

11 BIRTHPLACE OF FATHER (city or town) Hilton

(State or country) N.Y.

12 MAIDEN NAME OF MOTHER Nellie Corey

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Hilton N.Y.

14 Informant Mrs Anna Hunn

(Address) 428 Evesham Ave

15 Filed 19 C. HARRISON JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-6 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Gun Shot Wound Through Heart Suicide.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

Signed (Coroner) M. D.

7/8 1929 (Address) 3602 Roland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hilton New York Date of Burial 7/8 1929

20 UNDERTAKER William Cook ADDRESS 1217 N Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

8-1043

Spec.—1-10-21—M&T—1500 Blks.

22 6 5 5 8 E 47467

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 E 47467

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 2254 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sarah Morgan

(a) RESIDENCE No. 248 So Spring ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 13 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) June 21, 1929

7 AGE: Years — Months — Days 13 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work unknown

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Henriken

11 BIRTHPLACE OF FATHER (city or town) (State or country) S-Car —

12 MAIDEN NAME OF MOTHER Mary Morgan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md —

14 Informant Records - (Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 4 1929

17 I HEREBY CERTIFY, That I attended deceased from July 3 .1929. to July 4 .1929. that I last saw her alive on July 4 .1929. and that death occurred, on the date stated above, at 1.30 P m.

The CAUSE OF DEATH* was as follows:

Dysentery

(duration) ..... yrs. ..... mos 3 ds.

CONTRIBUTORY (Secondary) Prematurity (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? 248 So. Spring St. Balto.

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Macroscopic (+)

(Signed) F. C. Goodwin M. D.

7/4, 1929 (Address) J. H. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL HOPKINS HOSPITAL DATE OF BURIAL JUL 8 - 1929

20 UNDERTAKER ..... 19 .....

ADDRESS .....

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47468

CERTIFICATE OF DEATH.

E 47468

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 5135 Frankintown Road ST., 28-6 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benjamin Harrison Davis

(a) RESIDENCE NO. 5135 Frankintown Rd ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of May Davis

6 DATE OF BIRTH (month, day, and year) Apr 3-1879

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	50	3	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farm Hand.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER George W. Davis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Dicie Annie Bryant

13 BIRTHPLACE OF MOTHER (city or town) (State or country) South Carolina.

14 Informant Mrs. Dicie Ritter

(Address) 5135 Frankintown Rd

Filed JUL 15 1929, 19

C. HARRISON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7. 1929.

17 I HEREBY CERTIFY, That I attended deceased from Feby 18, 1929, to July 7, 1929.

that I last saw him alive on July 7, 1929

and that death occurred, on the date stated above, at 2.30 p. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Pancreas

(duration) — yrs. 5 mos — ds.

CONTRIBUTORY (Secondary) Carcinoma of Liver

(duration) — yrs. 4 mos. — ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo J Eberhart, M. D.

19 (Address) 5 E Madison St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Good Shepherd, Rockland — DATE OF BURIAL July 9 1929

20 UNDERTAKER John F. Denny — ADDRESS 715 Light St

THION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47469 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 47469

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 325 N. Carey St ST., 19-26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Florence Knight Dasch

(a) RESIDENCE NO. 325 N. Carey St ST., 18 WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White.

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Chas N. Dasch.

6 DATE OF BIRTH (month, day, and year): Jan 16 - 1851

7 AGE: Years 78. Months 5 Days 20 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Michael Knight

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ohio

12 MAIDEN NAME OF MOTHER: Mary Seavey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md.

14 Informant: Frank N. Dasch

(Address) 325 N. Carey St

15 Filed L 8 - 1929 19 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 6 - 29

17 I HEREBY CERTIFY, That I attended deceased from March 2 1929, to July 6 1929, that I last saw h alive on July 6 1929, and that death occurred, on the date stated above, at 2.40 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Arteriosclerosis

unknown (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Symptoms and Physical signs

(Signed) Charles Gelb, M. D.

July 7. 1929 (Address) 1111 W. Lanvale St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL: July 9 19 29

20 UNDERTAKER: Ellis S. White ADDRESS: 2564 Madison Ave

Important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Bks.

E 47470 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47470

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Baltimore, Maryland. REGISTERED NO. 5768

CITY OF BALTIMORE: (No. 1803 Braddish Ave. St. 15th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen Josephine Gleason

(a) RESIDENCE. No. 1803 Braddish Ave. St. 15th WARD.
(Usual place of abode)

Length of residence in city or town where death occurred 41 yrs — mos. — ds. How long in U. S., if of foreign birth? 49 yrs mos ds

(If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Married

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Edward E. Gleason

6 DATE OF BIRTH (month, day, and year) Jun. 3, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	5		
	59	6	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland.

PARENTS

10 NAME OF FATHER John Byrne

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland.

12 MAIDEN NAME OF MOTHER Margaret Ryan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland.

14 Informant Wm. P. Byrne (Address) 1735 Eastern Ave.

15 Filed JUL 8 - 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7th 1929.

17 I HEREBY CERTIFY, That I attended deceased from Feb. 15th, 1929, to July 7th, 1929, that I last saw her alive on July 6th, 1929, and that death occurred, on the date stated above, at 9 20 P.M.

The CAUSE OF DEATH* was as follows:

Septicemia

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus m 15 cellulitis of leg (duration) yrs. 5 mos. 14 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Laboratory

(Signed) Fred H. Cladt, M. D.

(Address) 3610 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Peters Cem.	July 9th 1929
20 UNDERTAKER J. E. Cowan & Son	ADDRESS 911 Eastern Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates. PHYSICIANS should state

Spec.—1-10-21—M&T—1500 Bks.

E 47471 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47471

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hospital ST. 7-13 WARD)

2-FULL NAME John E. Foltz, Jr.

(a) RESIDENCE NO. Reisterstown Rd. Dolphin WARD

(Usual place of abode)

Length of residence in city or town where death occurred ~~11~~ yrs. ~~6~~ mos. ~~15~~ ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12/22/07

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	11	6	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work school child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md.
(State or country)

PARENTS

10 NAME OF FATHER John E. Foltz

11 BIRTHPLACE OF FATHER (city or town) Del. No.
(State or country)

12 MAIDEN NAME OF MOTHER —

13 BIRTHPLACE OF MOTHER (city or town) Ant. No
(State or country)

14 Informant Mrs Grace Hafner
(Address)

15 7 - 8 - 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 1929.

17 I HEREBY CERTIFY, That I attended deceased from July 5, 1929. to July 7, 1929.

that I last saw h/ alive on July 7, 1929.

and that death occurred, on the date stated above, at 6.15 P.m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus
Diabetic Coma
Heart Failure

(duration) yrs. mos ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home.

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) B J Cohen ..., M. D.

, 19 (Address) Sinai Hos

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park — DATE OF BURIAL 7/10 1929

20 UNDERTAKER Wm H Berry mgr Dolphin — ADDRESS Reisterstown Md

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 47472

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47472

REGISTERED NO. 188

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hosp. St., 14-20 Ward)

2-FULL NAME Nelson Thomas

(a) RESIDENCE NO. Mc Donogh Md St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 7 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	C	Married

5a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of Mary Thomas

6 DATE OF BIRTH (month, day, and year) April 7 or 8 1863

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	66	3	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Gardiner
(b) General nature of industry, business, or establishment in which employed (or employer) Laundry Co
(c) Name of employer Thomas

9 BIRTHPLACE (city or town)
(State or country) Va

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Dont Know

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Dont Know

14 Informant Sam. R. Thomas
(Address) 1816 Madison Ave

15 Filed 19 C. HAMPSON JONES, M. D. Registrar
by

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-6 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Tetany - due to fracture of Lumbar R. the result of an automobile accident at Mc Donogh Md on the 29 June 1929 (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Mc Donogh Md
Did an operation precede death? no Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical

(Signed) L. Frame M. D.
7/8, 19 29 (Address) 29 39 Mc Elder

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Auburn Cem	July 9 1929

20 UNDERTAKER Charles H. Alexander ADDRESS 1404 Druid Hill Ave

L 8 - 1929

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state ... OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47473

CERTIFICATE OF DEATH

E 47473

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 4809 Holabird St., 26-36 Ward)

2-FULL NAME Sarah J Coburn

(a) RESIDENCE NO. 4809 Holabird St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 62 yrs. 10 mos. 24 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 Color or Race: white | 5 Single, Married, Widowed or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm J Coburn

6 DATE OF BIRTH (month, day, and year): Aug 13 1866

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	62	~~aug~~ 10	13 24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer): at Home
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country): Salt Lake City

PARENTS

10 NAME OF FATHER: John B Wrightsman

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Salt Lake City

12 MAIDEN NAME OF MOTHER: Sarah J Russell

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Canada

14 Informant (Address): Jno Coburn 4809 Holabird

15 Filed ..... 19.. C. HAMPSON JONES, M. D. Registrar

8-1929 By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 7 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) Sweldon yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 4809 Holabird

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Clinical

(Signed) Jones M Hampson, M. D.

July 9, 1929 (Address) 1002 Cham

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL: July 10th 1929

20 UNDERTAKER: Lilly & Guilfoile Inc. — ADDRESS: 403 N Gay

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47474

CERTIFICATE OF DEATH

44 E 47474

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3304 Foster Ave ST., 26 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Peter M. Dotterweich.

(a) RESIDENCE NO. 3304 Foster ave. ST., 26 WARD
(Usual place of abode)

Length of residence in city or town where death occurred 55 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mary Dotterweich

6 DATE OF BIRTH (month, day, and year) May 5th 1874

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
55	2	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Barber

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Andrew Dotterweich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Kunigunda Eckhardt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mary Dotterweich Wife

(Address) 3304 Foster Ave.

15 8-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6th 1929

17 I HEREBY CERTIFY, That I attended deceased from June 25 1929 to July 6 1929

that I last saw h alive on July 6 1929

and that death occurred, on the date stated above, at 12th P. m.

The CAUSE OF DEATH* was as follows:

Cancer of Liver.

From Autopsy

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) C. Hampson Jones M. D.

July 8 1929 (Address) 3508 Bank St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Cemetery	July 9th 1929
20 UNDERTAKER D. Kelly - Funeral Dir.	ADDRESS 405 S. Wolfe St.

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47475 16-802 E 47475

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. 20-69

CITY OF BALTIMORE: (No. Sydenham Hospital WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME DOROTHY DREWANZ

(a) RESIDENCE NO. 2543 Edmondson Ave. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 4 yrs. 8 mos. 21 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Oct 17, 1924

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	4	8	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John Drewanz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Lillian Coleman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant 2543 Edmondson Ave
(Address)

15 Filed 8-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 3, 1929, to July 8, 1929, that I last saw h or alive on July 8, 1929 and that death occurred, on the date stated above at 11 20 a m.

The CAUSE OF DEATH* was as follows:

Bacillary Dysentery

(duration) 0 yrs. 0 mos. 12 ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? 2543 Edmondson Ave

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Addison Craft Libby, M. D.

7-9 1929 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Franklin W Leib	July 10 1929
20 UNDERTAKER Cedar Hill Cemetery	ADDRESS 709 W Baltimore

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47476

CERTIFICATE OF DEATH

90 E 47476

1—PLACE OF DEATH Mercy Hospital

REGISTERED NO. 26-37

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ... ST. ... WARD)

2—FULL NAME Mrs Bertha Chassagne

(a) RESIDENCE NO. 59 Ponca St ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) WIFE of Ferdinand Chassagne

6 DATE OF BIRTH (month, day, and year) May 20 - 1893

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	36	1	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER ETIENNE G. CARY.

11 BIRTHPLACE OF FATHER (city or town) (State or country) France

12 MAIDEN NAME OF MOTHER Laura Wagner.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Mrs Wm Smith

(Address) 432 Main Ave.

15 Filed 8-1-29 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-6-29

17 I HEREBY CERTIFY, That I attended deceased from 7-5 —, 19 29, to 7-6-, 19 29,

that I last saw h[illegible] alive on 7 - 6 -, 19 29

and that death occurred, on the date stated above, at 11 20 A m.

The CAUSE OF DEATH* was as follows:

Rheumatic cardiovascular disease

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Decompensation

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical -

(Signed) J Fuyko, M. D.

7/6. 19 29 (Address) Mercy Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL 7-9-29

20 UNDERTAKER M. Fahey & Sons — ADDRESS 842 W North Ave.

important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 47477.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47477.

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3606 Hillsdale Road (ST.) 38-64 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma A. Eggleston

(a) RESIDENCE NO. 3606 Hillsdale Road ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs 11 mos. 1 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Charles S. Eggleston

6 DATE OF BIRTH (month, day, and year) August 6, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	70	11	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore (State or country) Maryland

PARENTS

10 NAME OF FATHER Elijah Carback

11 BIRTHPLACE OF FATHER (city or town) Baltimore (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sarah J. Fox

13 BIRTHPLACE OF MOTHER (city or town) Baltimore (State or country) Maryland

14 Informant Mrs. Ella F. Beard

(Address) 3606 Hillsdale Road

15 Filed 7-8-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7- 1929

17 I HEREBY CERTIFY, That I attended deceased from April 29, 1929, to July 7- 1929, that I last saw her alive on July 7- 1929 and that death occurred, on the date stated above, at 9.40 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

About 1 yrs. — mos. — ds.

(duration)

CONTRIBUTORY (Secondary) Inanition

(duration) — yrs. 1 mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No Clinical

What test confirmed diagnosis?

(Signed) C. K. Skilling, M. D.

7/8, 1929 (Address) 1120 E. Pratt

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL 7/9 1929

20 UNDERTAKER Henry U. Mears and Son

ADDRESS 505 N. Calvert

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 47478 HEALTH DEPARTMENT—CITY OF BALTIMORE **E 47478**

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No.) South Baltimore General Hospital (Street) (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Mary Heil

(a) RESIDENCE NO. 834 W. Hazel St, Newcastle Pa.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	white	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of August Heil

6 DATE OF BIRTH (month, day, and year) Apr 2-1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	54	3	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) Md

PARENTS

10 NAME OF FATHER Chas. Kistner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Margarete Belzer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs Margaret Schultz (Address) Manchester. Md

15 7-8-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-6-29

17 I HEREBY CERTIFY, That I attended deceased from 7-5, 1929, to 7-6, 1929, that I last saw her alive on 7-6, 1929 and that death occurred, on the date stated above, at 4 a. m.

The CAUSE OF DEATH* was as follows:

Diabetic Coma associated with uremia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Diabetis Mellitus

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Laboratory tests

(Signed) Joseph Laukaitis, M. D.

, 19 (Address) South Baltimore General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oaklawn Cem DATE OF BURIAL July 9 1929

20 UNDERTAKER Wm J. Tucker Sons ADDRESS N. & Fa.

Important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47479

CERTIFICATE OF DEATH.

31 ~ **E 47479**

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1214 N. Spring St. 10-C Ward)

2-FULL NAME David S. Johnson

(a) RESIDENCE NO. 1214 N. Spring St._____ Ward_____

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. ___ mos. ___ ds. How long in U. S., if of foreign birth? ___ yrs. ___ mos. ___ ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 10-1883

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	45	8	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber

(b) General nature of industry, business, or establishment in which employed (or employer) Himself

(c) Name of employer

9 BIRTHPLACE (city or town) Richmond

(State or country) Va

PARENTS

10 NAME OF FATHER David Johnson

11 BIRTHPLACE OF FATHER (city or town) Rich

(State or country) Va

12 MAIDEN NAME OF MOTHER Margret Oliver

13 BIRTHPLACE OF MOTHER (city or town) Rich

(State or country) Va

14 Informant (Address) Franklin Johnson 1237½ E. Gladstone

15 Filed 8 - 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 1929

17 I HEREBY CERTIFY, That I attended deceased from July 3 1929, to July 6 1929, that I last saw him alive on July 5 1929, and that death occurred, on the date stated above, at 12 10 noon

The CAUSE OF DEATH* was as follows:

Bypo- Nephritis

(duration) ___ yrs. 2 days mos. ___ ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) ___ yrs. ___ mos. ___ ds.

18 Where was disease contracted if not at place of death? Richmond

Did an operation precede death? no Date of ___

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Lab

(Signed) R. J. Ludwig, M. D.

7/7, 1929 (Address) 1429 E. Monument St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem Date of Burial 7-9 1929

20 UNDERTAKER Jas. M. Skinner ADDRESS 1625 E. Madison St

Upon should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47480

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 47480

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1331 N. Eden ST., 9-17 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Naomi E. Stalbert

(a) RESIDENCE NO. 1331 N. Eden ST., WARD 9
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 30 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Feb 19-1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	79	4	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Co. Md

PARENTS

10 NAME OF FATHER Wm Stalbert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co Md

12 MAIDEN NAME OF MOTHER Sarah Burnett

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co Md

14 Informant Mrs A" Perfer
(Address) 1331 N. Eden st

15 Filed 8-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7-1929

17 I HEREBY CERTIFY, That I attended deceased from Nov 4 - 1927, to July 7 - 1929, that I last saw h Ex alive on July 7 - 1929 and that death occurred, on the date stated above, at 830 P. m.

The CAUSE OF DEATH* was as follows:

Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremic Coma

(duration) — yrs. — mos. 1 - ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Edwin H. Fenby M. D.

. 19 (Address) 1223 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkland Balto Co Md	July 10 1929
20 UNDERTAKER Henry Lutz N.	ADDRESS 1203 Broadway

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47481

CERTIFICATE OF DEATH

E 47481

1-PLACE OF DEATH

City of Baltimore: (No. St Agnes Hosp St., 25-12 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Henry Wagner

(a) RESIDENCE NO. Sulphur Spring Road - Arbutus Md St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if of foreign birth yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Dont Know

6 DATE OF BIRTH (month, day, and year) Feb - 14 - 1858

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	71	4	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Wheelwright
(b) General nature of Industry, business, or establishment in which employed (or employer) Vehicular
(c) Name of employer ~~retired~~ Heffner

9 BIRTHPLACE (city or town) Germany
(State or country)

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) Dont Know
(State or country)

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) Dont Know
(State or country)

14 Informant Miss Annie Wagener
(Address) 304 S. Catherine St.

15 Filed 1929 G. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/6 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:
Bronch Pneumonia - due to fracture
comminuted ribs left side - the result
of being thrown from automobile
in which he was riding after
(duration) yrs. mos. ds.
CONTRIBUTORY it was struck by another
(Secondary) automobile driven by Samuel Leyh
(duration) yrs. mos. ds.
who was sent for action of
18 Where was disease contracted if not at place of death? grand Jury
Catonsville & Belsbon
Did an operation precede death? Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical

(Signed) G. Hamm, M. D.
7/8, 1929 (Address) G. Hamm

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	July 9 1929
20 UNDERTAKER	ADDRESS
George L. Schmidt & Son	Fred Ave.

L 8 - 1929

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

E 47482

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

124 E 47482

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. Church Howp + Infirmary St. 12-4 Ward)

(If death occurred a hospital or insti tion, give its NA instead of street a number.)

2-FULL NAME Mary Heil

(a) RESIDENCE NO. 615 S. Broadway St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Heil

6 DATE OF BIRTH (month, day, and year): Nov 17 1876

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	52	7	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md

PARENTS

10 NAME OF FATHER: Charles Jasel

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14 Informant: Albert Kirby

(Address): 3218 Chesterfield Ave

15 8-1929 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 7. 1929

17 I HEREBY CERTIFY, That I attended deceased from 6-30-29, 19..., to 7-5-29, 19..., that I last saw h[illegible] alive on 7-5-29, 19..., and that death occurred, on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Cholecystitis

(duration) ... yrs. ... mos. 7 ds.

CONTRIBUTORY (Secondary): Pulmonary Embolism

(duration) ... yrs. ... mos. 3 hrs

18 Where was disease contracted if not at place of death? Hosp

Did an operation precede death? Yes Date of 6-29-29

Was there an autopsy? No

What test confirmed diagnosis? Cholecystotomy

(Signed) Vernon H Norwood M. D.

, 19 (Address) Church Home Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn. Date of Burial: July 10 1929

20 UNDERTAKER: M. W. & Duplaga ADDRESS

don should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE.

E 47483

CERTIFICATE OF DEATH.

3 V E 47483

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital (St.) 15-21 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Allison Chambers

(a) RESIDENCE NO. 1514 N. mount ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	col	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of School boy

6 DATE OF BIRTH (month, day, and year) Sept. 10, 1922

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	6	9	26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work School Boy.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER Allison Chambers.

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. C.

12 MAIDEN NAME OF MOTHER Stussie montgomery

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. C.

14 Informant Allison Chambers.

(Address) 1514 N. mount St

15 F[illegible] 8-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-6-1929

17

I HEREBY CERTIFY, That I attended deceased from 4/30, 1929 to 7-6-, 1929, that I last saw h[illegible] alive on 7-6-, 1929, and that death occurred, on the date stated above, at 2:30 P.M.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

Mastoiditis

Cervical Glands

(duration) yrs. 3 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical & X Ray

(Signed) H. Jackson, M. D.

7, 1929 (Address) Cannot ascertain at present

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Calvary Cemetery — DATE OF BURIAL July 9 1929

20 UNDERTAKER Thomas E. Kelson — ADDRESS 303 Preastman St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

~~226880~~ B 47484

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

1-80 E 47484

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. 4-25 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Roosevelt Lowe

(a) RESIDENCE NO. 622 W. Fairmount ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 8/9/10

7 AGE — Years: 18 Months: 10 Days: 27 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer 040

(b) General nature of industry, business, or establishment in which employed (or employer): Unknown

(c) Name of employer: Unknown

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Georgia Lowe

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed: 1929 By: O. HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 1929

17 I HEREBY CERTIFY, That I attended deceased from July 4 1929 to July 6 1929, that I last saw him alive on July 6 1929, and that death occurred, on the date stated above, at 6.05 P m.

The CAUSE OF DEATH* was as follows:

Typhoid fever

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Perforation ileum with general peritonitis (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of July 4th 1929

Was there an autopsy? Yes

What test confirmed diagnosis? Operation and Autopsy

(Signed) George E. Finney, M. D.

July 7th 1929 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem DATE OF BURIAL July 9 1929

20 UNDERTAKER: Samuel Wensley ADDRESS 1118 Biddle

INSTRUCTIONS should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 47485 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

12 9 E 47485

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Provident Hospital ST. 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alice Savage

(a) RESIDENCE NO. 542 W Lanvale ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) 1861

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
68	-	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va.

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant [redacted] Address) Mrs. Ellen Savage 542 W Lanvale St

15 Filed 8-1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 1929

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1929, to July 6, 1929, that I last saw h[illegible] alive on July 6, 1929, and that death occurred, on the date stated above, at 4 00 A m.

The CAUSE OF DEATH* was as follows:

Hypertensive Cardio-Vascular & Renal Disease

(duration) yrs. 18 mos ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) George McDonald M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Cem. Long Green DATE OF BURIAL July 9 1929

20 UNDERTAKER Samuel E. Wemley ADDRESS 38 N Bridle

Spec.—1-12-23—M&T—500 Bks.

E 47486 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47486

CERTIFICATE OF DEATH. 90

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1808 Guilford Ave ST., 17-14 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Guy E Simmons

(a) RESIDENCE NO. 1808 Guilford Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (Write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mechanic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Cadillac Co

9 BIRTHPLACE (city or town) (State or country) Penna

PARENTS

10 NAME OF FATHER Francis Simmons

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Alice Shaybach

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant M E Simmons

(Address) 1808 Guilford Ave

15 Filed 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-6 1929

17 I HEREBY CERTIFY, That I attended deceased from 2-14 1929 to 7-6 1929 that I last saw him alive on 7-6 1929 and that death occurred, on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Myocardial Degeneration

(duration) yrs. mos 1- ds.

CONTRIBUTORY (Secondary) Aortic Stenosis

(duration) 1- yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) David Fuller M. D.

7/8, 1929 (Address) 1500 Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cathedral — DATE OF BURIAL 7/9/29

UNDERTAKER W. H. Cook — ADDRESS 1217 N. Paca St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

L 8

Spec.—2-29-28—L. F. S.—500 Bks.

E 47487. HEALTH DEPARTMENT—CITY OF BALTIMORE **E 47487.**

CERTIFICATE OF DEATH

1—PLACE OF DEATH Maryland General Hosp. REGISTERED NO. 185

CITY OF BALTIMORE: (No. Howard & Madison ST. 13-56 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs Mary Reilly

(a) RESIDENCE NO. 2701 Kate Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 18-1844

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	85	1	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER J. Wesley Jarvis

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER Eliza Carter

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Hosp. Record.
(Address)

Filed 8-1929 C. HAMPSON JONES, M. D. Registrar

By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 - 1929

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1929, to July 7, 1929, that I last saw h[illegible] alive on July 7, 1929 and that death occurred, on the date stated above, at 2:00 a. m.

The CAUSE OF DEATH* was as follows:

Fract femur (left)

(duration) yrs. mos. 39 ds.

CONTRIBUTORY (Secondary) Lobar Pneumonia (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. K. Kerfoot M. D.

7/7, 1929 (Address) Md General Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
David Ridgl	7/9 29
20 UNDERTAKER	ADDRESS
Wm Cook	121 E Lexington

IMPORTANT. See instructions on back of certificates. Exact statement of OCCUPATION is very OF DEATH in plain terms, so that it may be properly classified.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47488

REGISTERED NO. **E 47488**

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. B& O Coal Pier Curtis Bay. St. 2-4 Ward)

2-FULL NAME Frank H.Urbanski.

(a) RESIDENCE NO. 838 S.Bond St. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) Do not know

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	38	-------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Watchman B.& O.R.R.Co.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Pete Urbanski.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Poland.

12 MAIDEN NAME OF MOTHER Mary Kopanski.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Poland.

14 Informant Mary Urbanski.(mother)
(Address) 838 S.Bond St.

15 Filed JUL 9 1929 19 C. HANSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) Missing July 5, Body found July 7, 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Drowning.
Accidental fall from a wharf.

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.
18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? Inquiry

(Signed) [illegible] M. D.
7/8, 1929 (Address) 1017 E.Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cemetery Hollins Ferry Rd	July 9 1929

20 UNDERTAKER J.W. Ozgazewski ADDRESS 1900 Eastern Ave.

INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47489

CERTIFICATE OF DEATH

E 47489

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Johns Hopkins Hospital St. 56-37 Ward)

2-FULL NAME Filomena Juliano

(a) RESIDENCE NO. 3900 Clairmount Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Vincenzo Juliano

6 DATE OF BIRTH (month, day, and year) Apr 29/1879

7 AGE Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
50	2	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) At home
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Italy

PARENTS

10 NAME OF FATHER Michael Boechino

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Italy

12 MAIDEN NAME OF MOTHER Tessie Biancanella

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Italy

14 Informant Vincen Juliano
(Address) 3900 Clairmount Ave

Filed JUL 9 - 1929 E. HAMPTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) July 7/29 192

17 I HEREBY CERTIFY That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:
Cerebral Apoplexy

..... (duration) ..... yrs ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) J. S. Cain, M. D.

7/8/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus Cemetery	7/11 1929
20 UNDERTAKER George J Ruth	ADDRESS 1735 Harford Ave

INFORMATION REQUIRED FOR MEDICAL, STATISTICAL AND SANITARY PURPOSES—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47490 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47490

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1408 E. Preston ST. 9-17 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Isacey

(a) RESIDENCE NO. 1408 E. Preston st. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 2 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
F	White	Widowed

.a If married, widowed, or divorced HUSBAND of (or) WIFE of Late D. Isacey.

6 DATE OF BIRTH (month, day, and year) Jan. 14 1854

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
75	5	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER John Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Clara Seidel

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Charles G. Isacey

(Address) 1408 E. Preston st

15 Filed JUL 9 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 1929

17 I HEREBY CERTIFY That I attended deceased from June 20 1929 to July 7 1929.

that I last saw her alive on July 6 1929

and that death occurred on the date stated above at 2 A m.

The CAUSE OF DEATH* was as follows

Carcinoma of Liver

(duration) yrs mos. 18 ds.

CONTRIBUTORY (Secondary) Oedema Lungs

(duration) yrs mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) E. Gill Hall M. D.

7/8/ 1929 (Address) 1631 E. Fort Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Block Rock Cemetery Md DATE OF BURIAL July 9 1929

20 UNDERTAKER Geo. L. Rucks ADDRESS 1735 Harford Ave

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47491

CERTIFICATE OF DEATH

129 ✓

E 47491

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 934 N. Gilmor ST., 16-24 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lottie Towson

(a) RESIDENCE NO. 934 Gilmor ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Geo W. Towson

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer) 039

(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Va

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unk

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unk

14 Informant Alice Thompson
(Address) 934 N. Gilmor St

15 Filed JUL 9 1929, C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/6/29

17 I HEREBY CERTIFY, That I attended deceased from 6/27/29 to 7/6/29

that I last saw h. alive on 7/6/29

and that death occurred, on the date stated above, at 10.45 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Brights Disease

(duration) 1½ yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

7/8/29 (Address) 912 Gilmor St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn — DATE OF BURIAL 7-11 1929

20 UNDERTAKER John H. Tradum — ADDRESS 1029 Hand St

DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 47492 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

161 201

E 47492

Registered No.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2211 Pennsylvania Ave. St. 14-54 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME.... Francis Savoy

(a) Residence No. 2211 Pennsylvania Ave. St., Ward.

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. 4 How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. male

4-COLOR OR RACE, black

5-Single, Married, Widowed, or Divorced, (Write the word.) single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of

6-DATE OF BIRTH (month, day and year) July 2, 1929

7-AGE. ....yrs. ....mos. 4 ds.

If LESS than 1 day, ...hrs. or ....min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work....

(b) General nature of industry, business, or establishment in which employed (or employer)....

(c) Name of employer....

9-BIRTHPLACE (city or town) Baltimore, Md. (State or Country),

PARENTS.

10-NAME OF FATHER, Ernest Savoy

11-BIRTHPLACE OF FATHER (city or town) Brentley, Md. (State or Country), Maryland

12-MAIDEN NAME OF MOTHER, Mary Barnes

13-BIRTHPLACE OF MOTHER (city or town) Laplata (State or Country), Maryland

14-(Informant) Mary Savoy

(Address) 2211 Pennsylvania ave.

15-

JUL 9 - 1929

E. HAMILTON JONES, M. D.

Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 6, 1929

17- I HEREBY CERTIFY, That I attended deceased from July 2 1929 to July 6 1929 that I last saw him alive on July 6 1929 and that death occurred, on the date stated above, at 1:30 P. m.

The CAUSE OF DEATH* was as follows:

Prematurity (Claim # 2)

....(Duration)....yrs....mos....ds

CONTRIBUTORY (Secondary)

....(Duration)....yrs....mos....ds

18-Where was disease contracted if not at place of death?....

Did an operation precede death?.... Date of....

Was there an autopsy?....

What test confirmed diagnosis?....

(Signed) [illegible] M. D.

7/8, 1929 (Address) Emil Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Sacred Heart DATE OF BURIAL. 7/9/29

20-UNDERTAKER. John J. Fahey Sons ADDRESS. 1318 Light St

Should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47493

CERTIFICATE OF DEATH

45

E 47493

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Balto. City Hosp. ST. 18-26 WARD)

2—FULL NAME John J. Kaubell

(a) RESIDENCE NO. 752 W. Lexington ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Kate Kaubell

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Jno. J. Kaubell

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Mary Caton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Hospital Record

(Address)

15 Filed JUL 9 1929, 19 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/8/29

17 I HEREBY CERTIFY, That I attended deceased from 7/6, 1929 to 7/8, 1929

that I last saw him alive on 7/8, 1929

and that death occurred, on the date stated above, at 7½ a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma transverse colon

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Partial intestinal obstruction

Bronchopneumonia (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. U. Lumpkin, M. D.

7/8, 1929 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral	7/10 1929
20 UNDERTAKER John J. Raley Sons	ADDRESS 1318 Light St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47494 **E 47494**

CERTIFICATE OF DEATH

1—PLACE OF DEATH Mercy Hospital REGISTERED NO. 1857

CITY OF BALTIMORE: (No. 1357 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Elizabeth Newton

(a) RESIDENCE NO. 3511 Buena Vista Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

1 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 29 1861 (1861)

7 AGE: Years 67 Months 11 Days 5 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Practical nurse

(b) General nature of industry, business, or establishment in which employed (or employer): Self

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Harford County Maryland

PARENTS

10 NAME OF FATHER: Wm D Newton

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Martha Armitage

13 BIRTHPLACE OF MOTHER (city or town) (State or country): England

14 Informant: Ida L Newton

(Address): 3511 Buena Vista ave

15 Filed ..., 19... Registrar

C. HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7-7-29

17 I HEREBY CERTIFY, That I attended deceased from 7-4-, 1929, to 7-7-, 1929, that I last saw h er alive on 7-7-, 1929, and that death occurred, on the date stated above, at 3 40 P m.

The CAUSE OF DEATH* was as follows:

Fracture neck of femur left due to fall, which was accidental.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Terminal Pneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J Leyhe, M. D.

7-7-1929 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetary — DATE OF BURIAL: July 10 1929

20 UNDERTAKER: J Wm Davis — ADDRESS: 3307 Pinkney St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47495 38 E 47495

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 1725 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Williams

(a) RESIDENCE NO. 556 W. Biddle ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? ? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mamie Williams

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	40			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lather 058

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) ? South Carolina

PARENTS

10 NAME OF FATHER Frank Williams ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ? South Carolina

12 MAIDEN NAME OF MOTHER Margaret ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ? South Carolina

14 Informant Records of
(Address Baltimore City Hospitals

15 Filed JUL 8 - 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1929 to July 6, 1929.

that I last saw h~~im~~ alive on July 6, 1929

and that death occurred, on the date stated above, at 2:30 P. m.

The CAUSE OF DEATH* was as follows:

Syphilis

" Aorta c insufficiency

Myocarditis, Chronic Acute c enlargement I (duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Prostatitis ?

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Exam Autopsy

(Signed) Marvin H. McLean, M. D.

7-8, 1929 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion et	July 9 1929
20 UNDERTAKER	ADDRESS
A R Brown & Son	108 W. Monroe

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47496

HEALTH DEPARTMENT—CITY OF BALTIMORE

154

E 47496

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1615 E. Federal ST.) 8-17 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Gertrude L. Waldner

(a) RESIDENCE NO. 1615 E. Federal ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

(a) If married, widowed, or divorced ~~HUSBAND of~~ (or) WIFE of: Louis Waldner

6 DATE OF BIRTH (month, day, and year): Jan 13 57

7 AGE: Years 72 | Months 5 | Days 24 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): at Home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): City

PARENTS

10 NAME OF FATHER: August Schaeffer

11 BIRTHPLACE OF FATHER (city or town) (State or country): Del

12 MAIDEN NAME OF MOTHER: Minnie Fisher

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Del.

14 Informant: Louis Waldner

(Address): 1615 E Federal St.

15 Filed ... 19... Registrar

JUL 9 - 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 7/29

17 I HEREBY CERTIFY, That I attended deceased from June 10th 28 to July 7th 29

that I last saw h alive on July 7th 29 at 2 20 P.M.

and that death occurred, on the date stated above, at 2 20 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Pemphigus

(duration) 1 yrs. 0 mos. ds.

CONTRIBUTORY (Secondary) Hardening

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm H Jones M. D.

July 8, 1929 (Address) 1801 E Pratt St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cem.

DATE OF BURIAL: 7/10 1929

20 UNDERTAKER: Philip Herring

ADDRESS 2016 Orleans St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47497

CERTIFICATE OF DEATH

47 ✓ **E 47497**

1—PLACE OF DEATH

REGISTERED NO. 15-68

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2415 W. North Ave ST., (WARD)

2—FULL NAME Anna A. Dorsey

(a) RESIDENCE NO. 2415 W. North Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. 4 mos. 2 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

a If married, widowed, or divorced (or) WIFE of Lewis C. Dorsey

6 DATE OF BIRTH (month, day, and year) Feby 14-1878

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	51	4	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md (State or country)

PARENTS

10 NAME OF FATHER Adam Holmes

11 BIRTHPLACE OF FATHER (city or town) Balto Md (State or country)

12 MAIDEN NAME OF MOTHER Laura Fathel

13 BIRTHPLACE OF MOTHER (city or town) Balto Md (State or country)

11 Informant Lewis C. Dorsey

(Address) 2415 W. North Ave

Filed JUL 9 1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8-1929

17 I HEREBY CERTIFY, That I attended deceased from April, 1928, to July 8, 1929, that I last saw h alive on July 8, 1929 and that death occurred, on the date stated above, at 6 30 A m.

The CAUSE OF DEATH* was as follows:

General Carcinomatosis

Adeno Carcinoma of Left Breast

(duration) 2? yrs. mos. ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of June 1928

Was there an autopsy? No What test confirmed diagnosis? Clinical & Microscopic

(Signed) Sol. Wiseman M. D.

July 9, 1929 (Address) 4000 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem.

DATE OF BURIAL July 10 1929

20 UNDERTAKER Harry W. Ehlen

ADDRESS 1944 W. North Ave

IMPORTANT—CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47498 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 47498

REGISTERED NO.

1—PLACE OF DEATH Baltimore City Hospitals

CITY OF BALTIMORE: (No. ..... ST., 1-3 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank Dregier

(a) RESIDENCE NO. 706 S. Glover ST., ... WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., If foreign birth? — yrs. mos. ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Louis Dregier

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Libby ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Records of

(Address) Baltimore City Hospitals

15 Filed JUL 9 1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 2, 1929, to July 7, 1929, that I last saw him alive on July 7, 1929 and that death occurred, on the date stated above, at 8:45 P.M.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic Acute

Myocardial Insufficiency

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis; Emphysema

Chronic Bronchitis (duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Warren H. W. Low, M. D.

7-8, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Stanislaus, Bmre.	July 11" 1929
20 UNDERTAKER W. F. Sadowski	ADDRESS 2215 E. Pratt Street

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47499 — E 47499

CERTIFICATE OF DEATH

31

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1425 Ward ST. 21-28 WARD)

2—FULL NAME Henry Parker

(a) RESIDENCE NO. 1425 Ward ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Sarah Parker

6 DATE OF BIRTH (month, day, and year): 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: John Parker

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Sarah Lewis

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Sarah Parker

(Address): 1425 Ward

15 Filed ..., 19... [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7/7/29

17 I HEREBY CERTIFY, That I attended deceased from 6/20/29, 19..., to 7/7/29, 19..., that I last saw h... alive on 7/7/29, 19..., and that death occurred, on the date stated above, at 6 9 m.

The CAUSE OF DEATH* was as follows:

Pulmonary TB

(duration) ... yrs. 2 mos. ... ds.

CONTRIBUTORY (Secondary) Cardiac Insufficiency

(duration) ... yrs. ... mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Shepherd Brain M. D.

, 19 (Address) 1111 Druid Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn

DATE OF BURIAL: 7-9 1929

20 UNDERTAKER: Daniel Fortney

ADDRESS 916 Park Ave

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 47500 — **E 47500**

REGISTERED NO. 14006

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 613 Jasper ST., 125 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Graves

(a) RESIDENCE NO. 613 Jasper ST., ... WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widowed

5a If married, widowed, or divorced
~~HUSBAND of~~ (or) WIFE of Emory Graves

6 DATE OF BIRTH (month, day, and year) 1 - 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	73	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Kent Co
(State or country) Maryland

PARENTS

10 NAME OF FATHER Jerry Yorker

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant John Yorker
(Address) 613 Easter St

15 Filed ..... 1929 THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 1929

17 I HEREBY CERTIFY, That I attended deceased from July 5 1929 to July 7 1929

that I last saw her alive on July 6 1929

and that death occurred, on the date stated above, at 2.10 a m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) 1 yrs — mos — ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) ..... yrs. — mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Irregular

(Signed) W. F. Howell M. D.

, 19 (Address) 1191 Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cem — DATE OF BURIAL 7-9 1929

20 UNDERTAKER Daniel Easton & Co — ADDRESS 916

JUL 9 1929

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-22-28—L. F. S.—500 Bks.

E 47501

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47501

57

1—PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 802 N. Pennsylvania ST. 16-22 WARD)

2—FULL NAME Mrs. Mary Elizabeth Jackson

(a) RESIDENCE NO. 802 N. Pennsylvania ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

a If married, widowed, or divorced HUSBAND of (or) WIFE of: Harry Jackson

6 DATE OF BIRTH (month, day, and year): Oct. 15-1866

7 AGE — Years: 63 | Months: 8 | Days: 21 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Robt Adams

11 BIRTHPLACE OF FATHER (city or town) (State or country): Not known

12 MAIDEN NAME OF MOTHER: Linda Jones

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not known

14 Informant: Mrs. Harriet E. Gray

(Address) 802 N. Pennsylvania Ave

15 Filed JUL 9 1929 Dr. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 6th 1929

17 I HEREBY CERTIFY, That I attended deceased from July 5th, 1929, to July 6th, 1929

that I last saw h alive on July 6th, 1929

and that death occurred, on the date stated above, at 10 35 A.M. P.M.

The CAUSE OF DEATH* was as follows:

~~Acute~~ Diabetes Mellitus

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms & Coma

(Signed) A. E. Gelsell M. D.

19 (Address) 1 E. Franklin

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Laurel Lawn — DATE OF BURIAL: 7-9 1929

20 UNDERTAKER: Daniel Coates Dead — ADDRESS 916

IMPORTANT—WRITE PLAINLY WITH INK—This is a PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 47502 HEALTH DEPARTMENT—CITY OF BALTIMORE **E 47502**

91-002

CERTIFICATE OF DEATH.

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1203 S. Highland Ave. ST., 26 WARD)

2-FULL NAME Philip Kappel

(a) RESIDENCE NO. 1203 S. Highland Ave ST., 26 WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. . mos. ds. How long in U. S., if of foreign birth? 76 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elizabeth Kappel

6 DATE OF BIRTH (month, day, and year) Sept 4, 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	82	3	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Barber retired 20 yrs.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany.

PARENTS

10 NAME OF FATHER Not Known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Not Known.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Elizabeth Kappel.
(Address) 1203 S. Highland Ave

15 FILED JUL 9 - 1929 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7 - 7 - 1929

17 I HEREBY CERTIFY, That I attended deceased from May 31, 1929, to July 7, 1929, that I last saw him alive on July 7, 1929, and that death occurred, on the date stated above, at 5.40 p. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) Indefinite ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Geo. L. Edgeworth Cor M. D.

, 19 (Address) 606 S. Conkling Ave,

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cem.	July 10 1929
UNDERTAKER George W. Zirkle	ADDRESS 1737 E. Eager

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47503

CERTIFICATE OF DEATH

74-001 E 47503

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 514 S Washington St. (WARD) 7-4

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Maryanna Derenez

(a) RESIDENCE NO. 514 S. Washington St. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., If foreign birth? 17 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White	Married.

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Adam.

6 DATE OF BIRTH (month, day, and year) 1857.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland.

PARENTS

10 NAME OF FATHER Antoni Titowicz

11 BIRTHPLACE OF FATHER (city or town) Poland
(State or country)

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) Poland
(State or country)

14 Informant Adam Derene

(Address) 514 S Washington St

15 Filed JUL 9 - 1929 WILLIAM H. JONES, M. D.
By Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6-29

17 I HEREBY CERTIFY, That I attended deceased from July 1 29, to July 6 29

That I last saw her alive on July 6 29

and that death occurred, on the date stated above, at 10 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. 1 mos. 7 ds.

CONTRIBUTORY (Secondary) Cardiac Paralysis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Wm. Ray Sayer M. D.

(Address) 801 Fairmount Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cem. DATE OF BURIAL July 10 1929.

20 UNDERTAKER George A. Weber ADDRESS 705 S Ann St.

Spec.—2-29-28—L. E. S.—500 Bks.

E 47504

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

907

E 47504

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

CITY OF BALTIMORE: (No. 28-65 ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth Plitt

(a) RESIDENCE NO. 4211 Fernhill Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 79 yrs. — mos. — ds. How long in U. S., if foreign birth? ? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of George Plitt

6 DATE OF BIRTH (month, day, and year) Dec 27 1826

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
92	6	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) ? Germany

PARENTS

10 NAME OF FATHER Frederick Wurme ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) ? Germany

12 MAIDEN NAME OF MOTHER Caroline ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ? ?

14 Informant Records (Address) BALTIMORE CITY HOSPITALS

15 Filed ..... 19 ..... Registrar

JUL 9 - 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 1929

17 I HEREBY CERTIFY, That I attended deceased from 2-29, 19 28, to 7-7, 19 29,

that I last saw h[illegible] alive on 7-7, 19 29

and that death occurred, on the date stated above, at 10 30 p. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypertension: Arteriosclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Warren H. McLane, M. D.

7-8, 19 29 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	July 9 19 29
20 UNDERTAKER John F. Denny	ADDRESS 715 Cathedral St

C. [illegible] JONES, M. D.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47505

CERTIFICATE OF DEATH

E 47505

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE (No. Druid Hill Park St. 13-54 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George E. Nelson

(a) RESIDENCE NO. Unknown St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
M.	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
About 55				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer

9 BIRTHPLACE (city or town) ?

(State or country)

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town)

(State or country) ?

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) ?

14 Informant The police

(Address)

15 Filed ....., 19 C. HAMPTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 6/20 1927

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis

Straight Heart Surgery

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) [illegible], M. D. (Coroner)

6/23, 1927 (Address) 1032 Richardson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions Transients, or Recent Residents.)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

20 UNDERTAKER ADDRESS

1929

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

47506

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 47506

1-PLACE OF DEATH

City of BALTIMORE: (No. 1816 Madison Ave St. W-7 Ward)

Registered No.....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby Parker

(a) Residence No. 1816 Madison Ave St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX Male

4-COLOR OR RACE, Colored

5-Single, Married, Widowed, or Divorced, (Write the word.) Infant

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of Infant

6-DATE OF BIRTH (month, day and year) July 8, 29

7-AGE. ...yrs. ...mos. ...ds.

If LESS than 1 day, hrs. or 5 min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) -

(c) Name of employer -

9-BIRTHPLACE (city or town) Baltimore (State or Country)

PARENTS.

10-NAME OF FATHER, Clarence Parker

11-BIRTHPLACE OF FATHER (city or town) Connecticut (State or Country),

12-MAIDEN NAME OF MOTHER, Ruth Balkanson

13-BIRTHPLACE OF MOTHER (city or town) Virginia (State or Country),

14

(Informant).....

(Address).....

15-

Filed JUL 9 - 1929 C. HUMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 9, 29

I HEREBY CERTIFY, That I attended deceased from July 8 1929 to July 8 1929

that I last saw h... alive on July 8 1929

and that death occurred, on the date stated above at 12 m.

The CAUSE OF DEATH* was as follows:

Premature birth

Immaturity

(Duration) ...yrs. ...mos. ...ds.

CONTRIBUTORY (Secondary)

(Duration) ...yrs. ...mos. ...ds.

18-Where was disease contracted if not at place of death?

Did an operation precede death? ...Date of...

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John C Stewart M. D.

(Address) 734 W Lafayette Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL, DATE OF BURIAL, ...19...

20-UNDERTAKER, ADDRESS

Commissioner Health JUL 9 - 1929

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 47507 HEALTH DEPARTMENT—CITY OF BALTIMORE.

CERTIFICATE OF DEATH.

E 47507

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 936 Gunmont ave (STREET) (WARD) 16-15

2-FULL NAME Baby Brown

(a) RESIDENCE NO. 936 Gunmont ave (STREET) 10 (WARD)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Unmarried

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 6 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
				7 hr.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Robt Brown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mitchville Va.

12 MAIDEN NAME OF MOTHER Blanche Truesdale

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bristol Tenn

14 Informant Mrs. Blanche Brown
(Address) 936 Gunmont ave

15 Filed JUL 9 - 1929 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 6 1929

17 I HEREBY CERTIFY, That I attended deceased from 19 to 19

that I last saw h alive on 19

and that death occurred on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows

Premature Birth
4½ months

(duration) yrs mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. H. Thomas M. D.

(Address) 1128 N Caroline

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

JUL 9 - 1929

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21—M&T—1500 Bks.

E 47508

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 47508

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE; (No.) 722 W Franklin (St.) 17-7 (Ward)

2-FULL NAME Ruth Lloyd

(a) RESIDENCE NO. 722 W. Franklin ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 7 yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1922

7 AGE — Years: 7 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Man. (ld)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Camden S. C.

PARENTS

10 NAME OF FATHER: John Lloyd

11 BIRTHPLACE OF FATHER (city or town) (State or country): Camden S. C.

12 MAIDEN NAME OF MOTHER: Mary Carter

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Camden S. C.

14 Informant: Father
(Address)

15 Filed JULY 9 1929 19 H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8 1929

17 I HEREBY CERTIFY, That I attended deceased from July 5, 1929, to July 7, 1929, that I last saw h[illegible] alive on July 7, 1929, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

S. F. phthisis
Scarlet fever

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Salvarsan Administration

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Henry Glassman M. D.

, 19 (Address) 2687 Madison Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion Cem | DATE OF BURIAL: July 10, 29

20 UNDERTAKER: Adolphus Halstead | ADDRESS: 904 Eutaw St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MARGIN RESERVED FOR BINDING

Spec.—1-10-21 M&T 1500 Blks.

47509

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 47509

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1935 W. Lanvale ST., (WARD) 46-22

2-FULL NAME Julius David Mielcke

(a) RESIDENCE NO. 1935 W. Lanvale ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 39 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jeanette Bertha Mielcke

6 DATE OF BIRTH (month, day, and year) Oct 24th 1847

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	81	8	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer American Printing & Lith. Co.

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Mielcke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Lemantzke

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Frederick Mielcke

(Address) 2419 Arunah ave

15 Filed JUL 9 1929 C. THOMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7th 1929

17 I HEREBY CERTIFY, That I attended deceased from May 13, 1929, to July 7, 1929, that I last saw him alive on July 7, 1929, and that death occurred, on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of bladder

& oesophagus (mal)

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? P. E.

(Signed) Lemuel E. Todd, M. D.

7/8/1929 (Address) 735 N. Eutaw

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loraine Cem. DATE OF BURIAL 7/10/1929

20 UNDERTAKER Geo. Weber & Son ADDRESS 2503 Edmondson ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47510

CERTIFICATE OF DEATH

E 47510
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 728 W. Saratoga St. 18-26 Ward)

2-FULL NAME Clara Parker

(a) RESIDENCE NO. 728 W. Saratoga St., Ward
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female
4 Color or Race: Colord
5 Single, Married, Widowed or Divoreed, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Henry Parker

6 DATE OF BIRTH (month, day, and year): Oct 13-1886

7 AGE: Years 42 | Months 8 | Days 24 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: at home
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country): Va

PARENTS

10 NAME OF FATHER: William Robb

11 BIRTHPLACE OF FATHER (city or town)
(State or country): Va

12 MAIDEN NAME OF MOTHER: Nancy Bailey

13 BIRTHPLACE OF MOTHER (city or town)
(State or country): Va

14 Informant: Polly Robb
(Address) 728 W. Saratoga St

15 Filed ....., 19.... HAMILTON JONES, M. D. Registrar
JUL 8 - 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 7 — 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) ..... yrs. 1 mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zellet M. D.

7/8/ 1929 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Essex Co. Va

DATE OF BURIAL: July 9 1929

20 UNDERTAKER: Mrs Katie R. Williams

ADDRESS 322 N Schroeder St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47511

CERTIFICATE OF DEATH

E 47511

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST. 6-24 WARD)

2—FULL NAME Beatrice Johnson

(a) RESIDENCE NO. 812 N. Vincent st. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Separated

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1901

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore

(State or country) Maryland

PARENTS

10 NAME OF FATHER John Johnson

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Bertha Adams

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Hospital Records

(Address)

15 Filed JUL 9 - 1929 19 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 21, 19 29, to July 7, 19 29,

that I last saw her alive on July 7, 19 29

and that death occurred, on the date stated above, at 10.15 a. m.

The CAUSE OF DEATH* was as follows:

Broncho-pneumonia

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical and autopsy

(Signed) Henry C. Smith M. D.

7-8-. 19 29 Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	July 10, 1929
20 UNDERTAKER Mrs Kate R. Williams	ADDRESS 3220 Schroeder St

Spec.—12-9-25—A Co.—200 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47512

CERTIFICATE OF DEATH.

49 E 47512

REGISTERED NO.

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Church Home & Infirm. Ward) 19

2-FULL NAME Charles Evans

(a) RESIDENCE NO. 300 W. Broadway St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred ~~Wife~~ yrs. mos. ds. (If non-resident give city or town and State)

How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Mc Evans

6 DATE OF BIRTH (month, day, and year) March 29-1885

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	44	3	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Store 034

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer Self

9 BIRTHPLACE (city or town) Phila Pa

(State or country)

PARENTS

10 NAME OF FATHER Wm H B Evans

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Pa

12 MAIDEN NAME OF MOTHER Sarah A Marsh

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Md

14 Informant Wm H B Evans Jr.

(Address) Annapolis Md.

15 Filed JUL 9 - 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/8 1929

17 I HEREBY CERTIFY, That I attended deceased from 7/6 1929, to 7/8, 1929, that I last saw him alive on 7/8, 1929, and that death occurred, on the date stated above, at 1.20 P m.

The CAUSE OF DEATH* was as follows:

Papilloma of Bladder

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage from Bladder

(duration) yrs. 8 mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Autopsy

(Signed) Wm B. Wallace M. D.

, 19 (Address) Church Home & Infir

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — Date of Burial: July 11 1929

20 UNDERTAKER: Wehrain Conc — ADDRESS: 1217 N Paul St

JUL 9 - 1929 Park.

...—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

MARGIN RESERVED FOR BINDING

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47513

CERTIFICATE OF DEATH

1929 E 47513

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2305 E. Madison ST., 7-12 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Morsilla Eichhorn

(a) RESIDENCE NO. 2305 E. Madison ST., 7 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George J. Eichhorn

6 DATE OF BIRTH (month, day, and year): June 20 1856

7 AGE: Years 73 Months Days 16 If LESS than 1 day, hrs. or min.

74

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer): 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Lambert J. Zimhund

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary Schwingle

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: George J. Eichhorn

(Address) 2305 E. Madison St

15 Filed JUL 9 - 1929 WILLIAM H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 6. 1929

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1929, to July 6, 1929, that I last saw h alive on July 6, 1929, and that death occurred, on the date stated above, at 8 P. M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

Arterio Sclerosis

(duration) 2 mos. ds.

CONTRIBUTORY (Secondary) Acute Bronchitis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. T. Gardiner M. D.

July 9, 1929 (Address) 700 N. Wolfe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery — DATE OF BURIAL: July 10 1929

20 UNDERTAKER: William Cobb & Son — ADDRESS: 816 Monument

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 47514 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

194 E 47514

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 338 Biddle St. 11-24 WARD)

2-FULL NAME Nancy Hicks

(a) RESIDENCE NO. 338 Biddle ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F.

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Sam Hicks

6 DATE OF BIRTH (month, day, and year) 1833

7 AGE Years 96 Months Days

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) Private home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bridgeton NJ

PARENTS

10 NAME OF FATHER George W. Lane

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Davis (Mrs)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant William Hicks

(Address) 338 Biddle St

15 Filed JUL 9 - 1929 19 C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9th 1929

17 I HEREBY CERTIFY, That I attended deceased from July, 19 29, to July 9th, 19 29, that I last saw h alive on July 8, 19 29, and that death occurred, on the date stated above, at 7 30 P.M.

The CAUSE OF DEATH* was as follows:

Hypostatic Congestion of Lungs

(duration) 7 hrs.

CONTRIBUTORY (Secondary) Arteriosclerosis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. Lee Hicks M. D.

(Address) 54 Mosher

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Boydton Va — DATE OF BURIAL July 9, 1929

20 UNDERTAKER Mrs. P. G. Elliott — ADDRESS 725 Ashland Ave

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. AGE should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 47515

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

160 E 47515

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Md Gen Hosp 1-26 (ST.) (WARD)

2—FULL NAME Baby Girl Crum

(a) RESIDENCE NO. 676 Woodlay Rd (ST.) Dundalk (WARD)
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): S

5a If married, widowed, or divorced
HUSBAND of —
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): 7/8/29

7 AGE — Years | Months | Days: 1 | If LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER George Crum

11 BIRTHPLACE OF FATHER (city or town) (State or country): W Va

12 MAIDEN NAME OF MOTHER Willie Harner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): W Va

14 Informant: Hospital
(Address)

15 Filed JUL 9 1929, 19 — C. HAMPSON JONES, M. D. — Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7/9/29

17 I HEREBY CERTIFY, That I attended deceased from 7/9/29, 19..., to 7/9/29, 19..., that I last saw h[illegible] alive on 7/9/29 and that death occurred, on the date stated above, at 8:30 a.m.

The CAUSE OF DEATH* was as follows:

Prematurity

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) —

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

(Address) [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Morgantown W Va — DATE OF BURIAL: 7/9/29

20 UNDERTAKER: Harry A Witzke — ADDRESS: N-3 W Lombard St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47516

CERTIFICATE OF DEATH.

111-0 07

E 47516

REGISTERED NO._____

(If death occurred in a hospital or Institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. Church Home & Infirmary St.) Ward)

2-FULL NAME John Considine, Jr

(a) RESIDENCE NO. 4809 Olney Rd St. _____ Ward _____

(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Helen Considine

6 DATE OF BIRTH (month, day, and year): Feb 5. 1891

7 AGE

Years	Months	Days	If LESS than 1 day ..... hrs. or ..... min.
38	5	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Coal Business

(b) General nature of industry, business, or establishment in which employed (or employer): 045

(c) Name of employer: Self

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md

PARENTS

10 NAME OF FATHER: John Considine

11 BIRTHPLACE OF FATHER (city or town): Baltimore

(State or country): Md

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town): Baltimore

(State or country): Md

14 Informant: Edw A McGovern

(Address): 210 E Lexington St

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D. Registrar

JUL 9 - 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 19

July 6, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 6 1929, to July 8, 1929, that I last saw him alive on July 8 1929, and that death occurred, on the date stated above, at 8:40 A m.

The CAUSE OF DEATH* was as follows: Perforation of Duodenal Ulcer

(duration) ..... yrs. ..... mos. 3 ds.

CONTRIBUTORY (Secondary) Peritonitis

(duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of .....

Was there an autopsy? Yes

What test confirmed diagnosis? .....

(Signed) Vernon H. Mowatt, M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys, Govans Date of Burial 7/10 1929

20 UNDERTAKER: H. Cook ADDRESS: 1217 E Fond St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47517

CERTIFICATE OF DEATH

101-001 V

E 47517

1—PLACE OF DEATH: Baltimore City Hospitals

REGISTERED NO.

CITY OF BALTIMORE: (No. [illegible] ST. 69 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME: Victoria Stuckrath

(a) RESIDENCE NO. 2021 E. Jefferson ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 64 yrs. ? mos. ? ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: George Stuckrath

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	64			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): ? West Virginia

PARENTS

10 NAME OF FATHER: Mansfield Dotson

11 BIRTHPLACE OF FATHER (city or town) (State or country): ? West Virginia

12 MAIDEN NAME OF MOTHER: Maltilda Wigner

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ? West Virginia

14 Informant: Records of

(Address) Baltimore City Hospitals

15 Filed JUL 9 1929, L. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 8, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 19, 1929, to July 8, 1929, that I last saw her alive on July 8, 1929 and that death occurred, on the date stated above, at 5:30 P.m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) — yrs. — mos. 28 ds.

CONTRIBUTORY (Secondary): Myocarditis, acute

(duration) — yrs. — mos. 12 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) [illegible] M. D.

7-9, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park — DATE OF BURIAL: 7/11 1929

20 UNDERTAKER: [illegible] — ADDRESS: 1217 E. Pratt St

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS very important. See instructions on back of certificate.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47518

CERTIFICATE OF DEATH

8-11 166

E 47518

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Mercy Hospital. St. 8-11 Ward)

2-FULL NAME Margaret Lavelle.

(a) RESIDENCE NO. 1205 N. Curley St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. ——— ds. How long in U. S., if of foreign birth 31 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White.	Married.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ———

6 DATE OF BIRTH (month, day, and year) August 10, 1896.

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	32	10	28	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Ireland.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Wm. G. Zwicker.
(Address) 5829 Anthony Ave.

15 Filed ... 19...

JUL 9 1929 C. HAMPSON JONES, M. D. Registrar

By ———

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bichloride of Mercury poisoning.
Suicide.
Uraemia.

(duration) ... yrs. ... mos. 13 ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? S. Calto. St. June 25, 1929

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Edw. McKennedy, M. D.

7/8, 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mem. Cathedral	7/11 1929
20 UNDERTAKER	ADDRESS
Wm. Cook	1217 St. Paul St.

Spec.—2-29-28—L. F. 8—500 M.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47519

CERTIFICATE OF DEATH

E 47519

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Baltimore City Hospitals ST., (WARD) 9.3.5

REGISTERED NO. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Rutha

(a) RESIDENCE NO. 15 Albermarle st. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tin plate worker

(b) General nature of industry, business, or establishment in which employed (or employer) OSK

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER John Rutha

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Mary Pierce

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Records

(Address)

15 Filed JUL 9 - 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2, 1929

17

I HEREBY CERTIFY, That I attended deceased from April 29, 1929, to July 2, 1929, that I last saw him alive on July 2, 1929 and that death occurred, on the date stated above, at 2.15 p. m.

The CAUSE OF DEATH* was as follows:

(a) Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Henry C. Smith, M. D.

7-2, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL U. S. National Asn

DATE OF BURIAL 7-10 1929

20 UNDERTAKER Robert Brooks & Son

ADDRESS Calhoun Hollins sts

Spec.—2-29-28—L. F. S.—500 Bks.

E 47520 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47520

REGISTERED NO. 57

13-59

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 908 Whitelock ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rachel Liepman

(a) RESIDENCE NO. 908 Whitelock ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Oscar Liepman

6 DATE OF BIRTH (month, day, and year) Apr. 20th. 1854

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	2	17	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Lazarus ~~Westheimer~~ Fuld

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Regina Westheimer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. L. Leipman

(Address) 908 Whitelock St.

15 C. HAMPSON JONES, M. D. Registrar

JUL 9 - 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7th. 1929

17 I HEREBY CERTIFY, That I attended deceased from June 16, 1929, to July 7, 1929, that I last saw her alive on July 7, 1929 and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis - diabetes

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) cerebral hemorrhage

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? /

Did an operation precede death? No Date of /

Was there an autopsy? No

What test confirmed diagnosis? clinical

(Signed) I Frederick Lentz M. D.

July 8, 1929 (Address) Temple Garden Apts.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem.

DATE OF BURIAL 7/10/ 1929

20 UNDERTAKER Harris Sandhaus

ADDRESS 1524 W. Mt. Royal Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47521

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 47521

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 304 S. East Ave. ST 1-2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME JOHN G. C. KRICH

(a) RESIDENCE NO. 304 S. East Ave. ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Lena Krich

6 DATE OF BIRTH (month, day, and year) February 7, 1872

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	5	0	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cashier

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer C.D. Kenney Coffee Co.

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Louis Krich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Catherine Meyers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. Lena Krich (Wife)

(Address) 304 S. East Ave.

15 Filed JUL 9 - 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 26 1929 to July 7 1929 that I last saw ~~him~~ alive on July 7 1929 and that death occurred, on the date stated above, at 8.50 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Renal disease

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Typical signs

(Signed) E. B. Krich, M. D.

7/9/29 (Address) 408 E Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mount Carmel Cemetery

DATE OF BURIAL July 10 1929

20 UNDERTAKER Henry Sander & Sons, Inc.

ADDRESS BALTIMORE ST. & BROADWAY

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 47522

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 90

E 47522

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 116 E.Preston St. St. 11-19 Ward)

2-FULL NAME William P.Reeve.

(a) RESIDENCE NO. 116 E.Preston St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ~~3~~ mos. ds. How long in U. S., if of foreign birth 40 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, ~~XXXXXXXXXX~~ HUSBAND of ~~XXXXXXXX~~ Annette Reeve.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	60	----------		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Advertising salesman

(b) General nature of industry, business, or establishment in which employed (or employer) R.L.Polk & Co.

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Canada.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Do not know.

14 Informant Madam Roge.

(Address) 116 E.Preston St.

15 Filed ..... 19..... C. HAMPSON JONES, M.D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8, 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Organic disease of the Heart

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) [signature] M. D.

7/9 . 19 29 (Address) 1017 S.Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Tampa Florida

DATE OF BURIAL July 10 1929

20 UNDERTAKER Henry Sander & Sons, Inc

ADDRESS Baltimore St. & Broadway

JUL 9 - 1929

MARGIN RESERVED FOR BINDING

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47523

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

91-092

E 47523

1—PLACE OF DEATH

REGISTERED NO. 11-24

CITY OF BALTIMORE: (No. 703 Cathedral ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie M. Bogue

(a) RESIDENCE NO. 703 Cathedral St. ST.. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 80 yrs. 10 mos. — ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 8, 1848

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	80	10	29	

8 OCCUPATION OF DECEASED None

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Maryland.

PARENTS

10 NAME OF FATHER Henry Bogue

11 BIRTHPLACE OF FATHER (city or town) Newtownbutler
(State or country) County Fermanagh, Ireland

12 MAIDEN NAME OF MOTHER Ellen Tracey

13 BIRTHPLACE OF MOTHER (city or town) Clonas
(State or country) Ireland

14 Informant HENRY BOGUE, JR
(Address) 843 Park Ave. Balto Md.

15 Filed July 29, 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-8-29

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1928, to July 1929,
that I last saw h alive on July 7th, 1929
and that death occurred, on the date stated above, at 4.00 p m.

The CAUSE OF DEATH* was as follows:

Cerebral & peripheral Arteriosclerosis
Peripheral

(duration) 10± yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) Charles O'Donovan M. D.

July 9. 1929 (Address) 5 East Read St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cem	July 11th 1929
20 UNDERTAKER	ADDRESS
Henry J. Jenkins Sons	711 Cathedral St

Information, with CAUTION that THIS IS A PERMANENT RECORD. Every ... of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47524

90 V

E 47524

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2018 Mt Royal Terrace St., 1920 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Georgianna Smull

(a) RESIDENCE NO. 2018 Mt Royal Terrace WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of David Clay Smull

6 DATE OF BIRTH (month, day, and year) December 27 1840

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	88	6	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Benjamin Veale

11 BIRTHPLACE OF FATHER (city or town) (State or country) Charles County, Md

12 MAIDEN NAME OF MOTHER Ann Catherine Miltenberger

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant Miltenberger N. Smull

(Address) 2018 Mt Royal Terrace

15 Filed JUL 10 - 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8, 1929

17 I HEREBY CERTIFY, That I attended deceased from 1920 to July 8 1929, that I last saw h[illegible] alive on July 6 1929 and that death occurred, on the date stated above, at 2 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis - Chronic

(duration) 5 yrs and one mos. ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(duration) 4 yrs mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms, cardiac [illegible]

(Signed) Chas C. Lovell, M. D.

7/10, 1929 (Address) 8 E. Eager St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cemetery	July 10, 1929
20 UNDERTAKER	ADDRESS
H. W. Jenkins & Sons Co.	Eutaw & Lanvale Sts

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47525

CERTIFICATE OF DEATH

113 V

E 47525

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Wendover & Junister ST. 1729 WARD

2—FULL NAME Madesta Horton Brady

(a) RESIDENCE NO. Wendover & Junister ST. Rd. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed, or Divorced~~; (write the word): Single

5a If ~~married, widowed, or divorced~~ HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 27 1927

7 AGE: Years 1 | Months 11 | Days 12 | If LESS than 1 day, ...hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: S. P Brady Jr

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md.

12 MAIDEN NAME OF MOTHER: M. Willey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Baltimore Md

14 Informant: M. T. Willey

(Address): Wendover & Junister

15 Filed JUL 9 1929, 19 C. HAMPSON JONES M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 4 - 29

17

I HEREBY CERTIFY, That I attended deceased from July 5, 1929, to July 9, 1929,

that I last saw h[illegible] alive on July 9, 1929

and that death occurred, on the date stated above, at 12 20 P m.

The CAUSE OF DEATH* was as follows:

Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Convulsions

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) J. Thos Chatman, M. D.

July 9, 1929 (Address) 11 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Thomas Garrison Forest	July 10 1929
20 UNDERTAKER	ADDRESS
Henry H Jenkins & Co	Edmondson Ave & Collins

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 47526 HEALTH DEPARTMENT—CITY OF BALTIMORE **E 47526**

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2712 Allendale Road St.) (WARD) 45-6

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Elizabath Roberts

(a) RESIDENCE NO. 2712 Allendale Road. St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) WIFE of Charles E. Roberts

6 DATE OF BIRTH (month, day, and year) Jan-5-1876.

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	53	6	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Dorchester Co Md

PARENTS

10 NAME OF FATHER John A. Insley.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Dorchester Co Md.

12 MAIDEN NAME OF MOTHER Elizabeth Ford.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Dorchester Co Md

14 Informant Charles E Roberts

(Address) 2712 Allendale Road.

15 Filed JUL 9 - 1929

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 7 1929

17 I HEREBY CERTIFY, That I attended deceased from June 10, 1929, to July 7, 1929, that I last saw h alive on July 7, 1929, and that death occurred, on the date stated above, at 10:30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) C. C. Hann M. D.

7/9 1929 (Address) 39 or Fremont Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cemetery — DATE OF BURIAL: July 10 1929

20 UNDERTAKER: Hughes Jones Inc — ADDRESS: 1324 N. Broadway

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

(Virginia W. Amos)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47527

168

E 47527

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

City of BALTIMORE: (No. 812 N. Monroe St. 12 Ward)

REGISTERED NO. _____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Virginia W. Amos.

(a) RESIDENCE NO. 812 N. Monroe St. 12 Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 2 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Harry V. Amos.

6 DATE OF BIRTH (month, day, and year): Aug 9 1874

7 AGE: 54 Years 55 | Months 10 | Days 18 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House keeping

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country): Balto Co. Md.

PARENTS

10 NAME OF FATHER: Geo B. Custer.

11 BIRTHPLACE OF FATHER (city or town)

(State or country): Md.

12 MAIDEN NAME OF MOTHER: Virginia Bard

13 BIRTHPLACE OF MOTHER (city or town)

(State or country): Germany

14 Informant: Mrs Robt Smith.

(Address) 812 N. Mo. Ave.

15 Filed 1929 C. HAMPSON JONES, M. D. Registrar

Rec'd

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/9 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, Autopsy or Inquiry) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Strangulation

Hanging by her Neck with a Rope. Suicide.

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) John Fitzpatrick M. D.

(Coroner)

7-9, 1929 (Address) 1632 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Md. Date of Burial

Baptist Cem. Hartford Co. July 11 1929

20 UNDERTAKER: Hartlinger & Cook ADDRESS: Benson

GL 9 - 1929

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

E 47528

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001 ✓ E 47528

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 2311 Jefferson St. 6-10 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John W Kwiak

(a) RESIDENCE NO. 2311 Jefferson St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie Kwiak

6 DATE OF BIRTH (month, day, and year) May 15 1885

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	44	1	18 23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocery Clerk

(b) General nature of industry, business, or establishment in which employed (or employer) 69

(c) Name of employer

9 BIRTHPLACE (city or town)

(State or country) Austria

PARENTS

10 NAME OF FATHER John Kwiak

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Austria

12 MAIDEN NAME OF MOTHER Lyskowska

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Austria

14 Informant Jennie Kwiak

(Address) 2311 Jefferson St

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

JL 9 - 1929 RRH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-8-29 19

17 I HEREBY CERTIFY, That I attended deceased from 7-1-29 19 to 7-8-29 19

that I last saw him alive on 7-8-29 19

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Jerome Kaltenbach, M. D.

7-8-29 (Address) 2214 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Date of Burial July 10 1929

20 UNDERTAKER Fred Crockett ADDRESS Woodlawn

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47529

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47529

CERTIFICATE OF DEATH

129

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2408 McElderry ST., 7-10 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Vachosky

(a) RESIDENCE NO. 2408 McElderry ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. mos. ds. How long in U. S., if foreign birth? 46 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Vachosky

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Austria

PARENTS

10 NAME OF FATHER John Vachosky

11 BIRTHPLACE OF FATHER (city or town) (State or country) Austria

12 MAIDEN NAME OF MOTHER Emma Mecka

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Austria

14 Informant Mary Vachosky

(Address) 2408 McElderry

15 JUL 9 - 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9/29

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1929 to July 9, 1929

that I last saw him alive on July 7, 1929

and that death occurred on the date stated above, at 8:30 A. m.

The CAUSE OF DEATH* was as follows: Uremia Acute Glomerulonephritis

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Evidence

(Signed) J. J. Kaufman M. D.

7-9, 1929 (Address) 600 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	July 12 19 29
20 UNDERTAKER	ADDRESS
Frank Brochlon	1000 Wood

U. S.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47530

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47530

REGISTERED NO. 20-69

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2215 W. Lexington ST., (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ella Mary Taylor

(a) RESIDENCE NO. 2215 W. Lexington ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

6 DATE OF BIRTH (month, day, and year) Nov 2, 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	3	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Examiner

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Erlanger

9 BIRTHPLACE (city or town) (State or country) Pa

PARENTS

10 NAME OF FATHER William Taylor

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pa

12 MAIDEN NAME OF MOTHER Annie Crawford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa

14 Informant Emma Smith

(Address) 2215 W Lexington St

15 Filed JUL 9 1929, 19

C. HAMILTON JONES, M. D.
Registrar

Per RHW

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8 1929

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1929 to July 8, 1929

that I last saw alive on July 6, 1929

and that death occurred, on the date stated above, at 3:40 P m.

The CAUSE OF DEATH* was as follows:

Uremia.
Metastatic Carcinoma of Lungs
Secondary Carcinoma of Breast. 5 yrs after Operation

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocardial Sclerosis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

7/8, 1929 (Signed) Benj. McCleary, M. D.

(Address) 7 W Mulberry St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount

DATE OF BURIAL 7/10 19 29

20 UNDERTAKER J. H. Cook

ADDRESS 1217 N Fulton Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47531

Lt Harbor 3321 Frederick Ave

40 **E 47531**

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4107 Frederick Ave ST. 20-71 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary E Tilert

(a) RESIDENCE NO. 4107 Frederick Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 72 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 8. 1857

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Catonsville Md

PARENTS

10 NAME OF FATHER John Tilert

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Christine Lumbach

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Louise E Tilert

(Address) 4107 Frederick Ave

15 Filed JUL 9 1929, 19 C. HAMPSON JONES, M. D. Registrar

Per RKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8. 1929

17 I HEREBY CERTIFY, That I attended deceased from Mar 24, 1929, to July 8, 1929, that I last saw her alive on July 5, 1929 and that death occurred, on the date stated above, at 11 30 P m.

The CAUSE OF DEATH* was as follows:

Hypertension

(duration) mos.

CONTRIBUTORY (Secondary) Cardiac decompensation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin & Phy Exam

(Signed) J. T. Kruger, M. D.

19 (Address) 3321 Frederick Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL 7/11 1929

20 UNDERTAKER L. H. Cook

ADDRESS 421 St Paul St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47532

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 47532

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 317 S Paca ST. 19-28 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna Louise Benson

(a) RESIDENCE NO. 317 S Paca ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 34 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of: Geo Benson

6 DATE OF BIRTH (month, day, and year): Oct 25, 1871

7 AGE — Years: 57 | Months: 8 | Days: 3 | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: At Home

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: John Kline

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Barbara Cook

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Mrs Geo. Cook

(Address): 130 Hilton St

15 Filed: JUL 9 1929 C. HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 8, 1929

17 I HEREBY CERTIFY, That I attended deceased from 6/25/, 1929, to 7/8, 1929, that I last saw h[illegible] alive on 7/8/29, 19[illegible] and that death occurred, on the date stated above, at [illegible] m.

The CAUSE OF DEATH* was as follows:

Cerebro vascular Renal Dis. a Decompensation
+ Hypertension
(Myocarditis)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Cerebral Apoplexy

(duration) Immediate yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Usual

(Signed) Bernard Terry, M. D.

7/11, 1929 (Address) 4 o W. Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet

DATE OF BURIAL: 7/10, 1929

20 UNDERTAKER: W. J. Cook

ADDRESS: 1718 E Fayette St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

JUL 9 - 1929

Spec.—1-12-23—M&T—500 Bks.

E 47533

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47533

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Little Sisters of the Poor St. 1014 WARD) 74

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Michael Hogan

(a) RESIDENCE NO. 1200 Valley ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1854

7 AGE: Years 75; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Ferdinand Hogan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary Hogan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Little Sisters of the Poor (Address) 1200 Valley St.

15 Filed JUL 9 1929, 19 [illegible] Registrar

C. HANSON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8th 1929

17 I HEREBY CERTIFY, That I attended deceased from 7/3 1929, to 7/8 1929, that I last saw h alive on 7/7 1929, and that death occurred, on the date stated above, at 4-30 p. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. Bernard Ross, M. D.

7/9, 1929 (Address) 1216 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Annapolis, Md. DATE OF BURIAL: 7/10 1929

20 UNDERTAKER: J. H. Cook ADDRESS: 1217 St Paul St

NB.—WRITE PLAINLY, WITH UNFADING INK—THIS BLANK PERMANENT RECORD. Every question should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 47534 22 47534

HEALTH DEPARTMENT—CITY OF BALTIMORE E 47534

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL (St.) 7864 100-801 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Grace Warner

(a) RESIDENCE No. 2305 Guyon ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 12/13/28

7 AGE Years Months 6 7 Days 25 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Daniel W. Warner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Mass

12 MAIDEN NAME OF MOTHER Grace Pratt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Mass

14 Informant (Address) Records JOHNS HOPKINS HOSPITAL

15 Filed JUL 9 1929, 19

HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8 1929

17 I HEREBY CERTIFY, That I attended deceased from July 6, 1929, to July 8, 1929, that I last saw her alive on July 8, 1929, and that death occurred, on the date stated above, at 10 20 P m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos 4 ds.

CONTRIBUTORY (Secondary) Amyotonia congenitalis

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? home

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Phys. Exam.

(Signed) J. C. Goodwin, M. D.

7/9, 1929 (Address) J. H. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Stockbridge Mass

DATE OF BURIAL: 7/9 1929

20 UNDERTAKER: J. M. Cook

ADDRESS: 1217 E. Fred St

N.B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

2 E 47535

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

3 E 47535

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. 14-20 (WARD)

2-FULL NAME Audrey Pye

(a) RESIDENCE NO. 2028 McCulloh ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Black	baby

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 19-28

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
	11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Child - dd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md -

PARENTS

10 NAME OF FATHER Chas - Pye

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md -

12 MAIDEN NAME OF MOTHER Amelia Hynes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md - U.S. -

14 Informant Parents -

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUL 10 1929 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8 1929

17 I HEREBY CERTIFY, That I attended deceased from June 16. 1929. to July 8. 1929.

that I last saw her alive on July 8. 1929.

and that death occurred, on the date stated above, at 3 15 P m.

The CAUSE OF DEATH* was as follows:

Tuberculous meningitis

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) G. C. Godwin M. D.

7/8. 1929 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Star Cem DATE OF BURIAL 7/12 1929

UNDERTAKER Samuel H. Hendrickson ADDRESS 578 Bond

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

2 26 798

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 47536

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 12-51 WARD)

2-FULL NAME Florence Boblits

(a) RESIDENCE No. 3174 Kennington ST. Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

100-001

E 47536

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE — Years: 69 — Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md—

PARENTS

10 NAME OF FATHER: Michael Boblits

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md—

12 MAIDEN NAME OF MOTHER: Priscilla Royston

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md—

14 Informant: Friends—

(Address) JOHNS HOPKINS HOSPITAL

Filed JUL 10 1929 . 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 9 1929

17 I HEREBY CERTIFY, That I attended deceased from July 1 . 1929. to July 9 . 1929.

that I last saw her alive on July 9 . 1929.

and that death occurred, on the date stated above, at 3 20 p.m.

The CAUSE OF DEATH* was as follows:

Toxic adenoma, Thyroid

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary): Bronchopneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. A. Gladstone M. D.

, 19 (Address) J. Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys Kanyodeen

DATE OF BURIAL: 7/11 1929

UNDERTAKER: Wm Cook

ADDRESS: 1217 St Paul

1.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Hopper

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47537

CERTIFICATE OF DEATH

57

E 47537

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE; (No. 3909 Park Heights Ave. WARD)

2—FULL NAME George J. Hopper

(a) RESIDENCE NO. 3909 Park Heights Ave. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Annie L. Hopper

6 DATE OF BIRTH (month, day, and year) July 29. 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	59	11	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) Investment

(c) Name of employer Friedman & Co

9 BIRTHPLACE (city or town) (State or country) Ohio

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mrs. Annie L. Hopper

(Address) 3909 Park Heights Ave

15 Filed JUL 10 1929 G. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 3-1929

17 I HEREBY CERTIFY, That I attended deceased from May 16, 1929, to July 7, 1929, that I last saw h in alive on July 3, 1929 and that death occurred, on the date stated above, at 10.10 P m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Diabetes Mellitus

(duration) 10 yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of -

Was there an autopsy? No

What test confirmed diagnosis? usual

(Signed) Edwin G. Mayer, M. D.

7/9, 1929 (Address) The Gladstone

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Woodlawn Cem. DATE OF BURIAL July 10 1929

20 UNDERTAKER J. J. Tuckey Sons ADDRESS [illegible]

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JUL 10 1929

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47538

CERTIFICATE OF DEATH

REGISTERED No. **E 47538**

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Sydenham Hospital WARD)

2—FULL NAME Margaret Johnson

(a) RESIDENCE NO. 644 W. Mulberry ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. 3 mos. 24 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 15, 1928

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	3	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer) Home

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Frank Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Hagerstown Md

12 MAIDEN NAME OF MOTHER Nancy Banks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Richmond Va

14 Informant Frank Johnson

(Address) 644 W Mulberry St

15 Filed JUL 10 1929 H. A. M. [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 24, 1929, to July 9, 1929, that I last saw her alive on July 9, 1929, and that death occurred, on the date stated above, at 12 45 a.m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) 0 yrs. 0 mos. 20 ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? 644 W. Mulberry St.

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings & Spinal puncture

(Signed) Addison Croft Clark, M. D.

7-9, 1929 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Olivet Cem	July 10 1929

20 UNDERTAKER Daniel Easton ADDRESS Mt Pleasant Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47539

CERTIFICATE OF DEATH

1851 E 47539

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Md Gen Hosp. St. H-25 Ward)

2-FULL NAME John R. Cherry

(a) RESIDENCE NO. 526 W. Saratoga St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Ada Cherry.

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	42	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) N. C.
(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) N. C.
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) N. C.
(State or country)

14 Informant Ada Cherry
(Address) 526 W Saratoga

Filed JUL 10 1929 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) July 5th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH was as follows:

Accident
Fractured Skull.
Railroad

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Care in head caught between timber

(duration) yrs. mos.

18 Where was disease contracted if not at place of death? 37th & Tudor Ave Balto

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) H. C. Flick, M. D.

July 6th 1929 (Address) Coroner.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	July 10 1929

20 UNDERTAKER Arnold Eareton ADDRESS 916 Penn Ave

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 47540 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47540

CERTIFICATE OF DEATH.

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4512 Mansfield Av ST. 27-44 (WARD) 29

REGISTERED NO E 47540

If death occurred in a hospital or institution, give its NAME instead of street and number

2-FULL NAME Delia M. Norton

(a) RESIDENCE No. 4512 Mansfield Av ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. ? mos. ? ds. How long in U. S., if of foreign birth? 28 yrs. ? mos. ? ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married,

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Michael Norton

6 DATE OF BIRTH (month, day, and year): May 25, 1876

7 AGE — Years: 53 — Months: 1 — Days: 12 — If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Patrick Conlon

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Ann Conlon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland.

14 Informant: Rose Conlon - Sister

(Address): 4512 Mansfield Av

15 Date received: JUL 10 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 7 1929

17 I HEREBY CERTIFY, That I attended deceased from June 16 1929 to 7/7/29 19 .

that I last saw her alive on 7/7/29 19

and that death occurred, on the date stated above, at 6:07 P. m.

The CAUSE OF DEATH* was as follows:

Myocardial Insufficiency

(duration) ..... yrs. ..... mos. 2 ds.

CONTRIBUTORY (Secondary) Chr. Nephritis - chr.

(duration) 2 yrs. ? mos. ? ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 6/5/29

Was there an autopsy? No.

What test confirmed diagnosis? Typical Evidence

(Signed) Geo. B. Lyncott, M. D.

, 19 (Address) 2802 Hartford Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral — DATE OF BURIAL: July 11 1929

20 UNDERTAKER: Rita Wiedefeld — ADDRESS: 914 Fremont Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47541

CERTIFICATE OF DEATH

6-37 113

REGISTERED NO. E 47541

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 470 r. Eastern ave ST. 6 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Kariviris

(a) RESIDENCE NO. 470 r Eastern av ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) 6/2/1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. Md
(State or country)

PARENTS

10 NAME OF FATHER Harry Kariviris

11 BIRTHPLACE OF FATHER (city or town) Greece
(State or country)

12 MAIDEN NAME OF MOTHER Mary Kariviris

13 BIRTHPLACE OF MOTHER (city or town) Greece
(State or country)

14 Informant Harry Kariviris

(Address) 470 r Eastern av

15 Filed JUL 10 1929 C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/10/29

17 I HEREBY CERTIFY, That I attended deceased from July 9, 1929 to July 9 1929, that I last saw h er alive on July 9 1929 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows: Pneumonia

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Bronchitis Acute

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? 0 Date of

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) J. M. Greenberg, M. D.

19 (Address) 463 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL 7/10/29

20 UNDERTAKER George J. Ruth

ADDRESS 1735 Hanford Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47542 E 47542

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 110 S. Broadway ST. 3-4 WARD)

REGISTERED NO. 1642

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sallie Hutton

(a) RESIDENCE NO. 110 S. Broadway ST. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 82 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 14, 1847

7 AGE Years 82 Months Days 24 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Robert Hutton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. Md.

12 MAIDEN NAME OF MOTHER Caroline Harrington

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. Md.

14 Informant Miss. Florence Hutton

(Address) 110 S. Broadway

15

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8, 1929

17

I HEREBY CERTIFY, That I attended deceased from July 8 1929 to July 8th 1929.

that I last saw her alive on July 8. 1929

and that death occurred, on the date stated above, at 2 P.M.

The CAUSE OF DEATH* was as follows:

Natural Causes — Senility

(duration) yrs mos ds.

CONTRIBUTORY (Secondary) old age - Arteriosclerosis

(duration) yrs 2 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) J. W. Wade, M. D.

19 (Address) 118 S Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Green Mount Cemy DATE OF BURIAL July 11 1929

20 UNDERTAKER John O. Mitchell & Sons ADDRESS 1900 Eutaw St.

JUL 10 1929

C. HAMPSON JONES, M. D. Registrar

Per

B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47543

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47543

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. UNIVERSITY HOSPITAL ST. 4-30 WARD)

2—FULL NAME MRS IDA SAUNDERS

(a) RESIDENCE NO. PULASKI, VA ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. 2 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Widowed

6 If married, widowed, or divorced HUSBAND of (or) WIFE of W. A. F. Saunders

6 DATE OF BIRTH (month, day, and year) Dec 2, 1868

7 AGE	60 Years	Months	Days	If LESS than 1 day, hrs. or min.
60	61	7	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Churchill, Md

PARENTS

10 NAME OF FATHER Wm H. Safford

11 BIRTHPLACE OF FATHER (city or town) (State or country) Churchill Md

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Churchill Md

14 Informant Wm H. Saunders (Son)

(Address) Pulaski, Va.

15 Filed JUL 10 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 13, 1929, to July 9, 1929, that I last saw her alive on July 8, 1929 and that death occurred, on the date stated above, at 3 A - m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Transverse Colon, with Metastasis to omentum + Mesentery

(duration) yrs. 16 mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of June 20, 1929

Was there an autopsy? Yes

What test confirmed diagnosis? Laboratory Exam of Specimen

(Signed) Lucien E. Little, M. D.

, 19 (Address) University Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemy

DATE OF BURIAL July 11, 1929

20 UNDERTAKER

ADDRESS Paul C. Mitchell & Son 1900 Eutaw Pl.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

47544

CERTIFICATE OF DEATH

E 47544

REGISTERED NO.

1-PLACE OF DEATH Aged Mens Home

City of BALTIMORE: (No. 1400 W Lexington St. 14-27 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louis Dietz

(a) RESIDENCE NO. 1400 W Lexington St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 76 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widower

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): April 1853

7 AGE — Years: 76 Months: 3 Days: 29 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country): Md

PARENTS

10 NAME OF FATHER: Valentine Dietz

11 BIRTHPLACE OF FATHER (City or town): Baltimore

(State or country): Md

12 MAIDEN NAME OF MOTHER: Elizabeth Smith

13 BIRTHPLACE OF MOTHER (city or town): Baltimore

(State or country): Md

14 Informant: Mary Forestal

(Address) 400 W Lexington

15 Filed JUL 18 1929 HAMILTON JONES, M. D. Registrar

Per Rose

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 9 1929

17 I HEREBY CERTIFY, That I attended deceased from 2/20 1928 to 7/9 1929

that I last saw him alive on 7 1929

and that death occurred, on the date stated above, at 6:15 A.m.

The CAUSE OF DEATH* was as follows: Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edwin B. Jones

. 19 (Address) 1115 St Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	Date of Burial
Trinity Cemetery	July 12 1929
20 UNDERTAKER Charles A. Kerner	ADDRESS 1533 Hollins

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47545

CERTIFICATE OF DEATH.

162 E 47545

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1024 Mc Culloh ST. 11-24 (WARD)

2-FULL NAME Mary Jotun

(a) RESIDENCE NO. 1024 Mc Culloh ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 9, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, 2 hrs. or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country) Md

PARENTS

10 NAME OF FATHER Jimmy Jotun

11 BIRTHPLACE OF FATHER (city or town) Cuba City
(State or country)

12 MAIDEN NAME OF MOTHER Ora Briggs

13 BIRTHPLACE OF MOTHER (city or town) Cuba City
(State or country) Wis

14 Informant
(Address)

15 Filed , 19 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9 1929

17 I HEREBY CERTIFY, That I attended deceased from July 9, 1929, to July 9, 1929, that I last saw h[illegible] alive on July 9, 1929, and that death occurred, on the date stated above, at 11 9 m.

The CAUSE OF DEATH* was as follows:

Congenital atelectasis

(duration) yrs. mos ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] Carey, M. D.

, 19 (Address) 102 Cadge

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL — DATE OF BURIAL

JOHNS HOPKINS HOSPITAL — 19

20 UNDERTAKER — ADDRESS

C. HAMPSON JONES, M. D. — Commissioner of Health

JUL 10 1929

GL 10523

I. WRITE PLAINLY, with pen and ink. Use no abbreviations. All the items of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—6-9-19—H. P. Co.—1000 Rks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47546

CERTIFICATE OF DEATH.

E 47546

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 611 N. Bentalou St ST.: 16-64 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Conrad Long.

(a) RESIDENCE. NO. 611 N. Bentalou St ST., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs mos ds

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Widowed.

5a If married, widowed, or divorced HUSBAND of ~~(or)~~ WIFE of Mary C. Long.

6 DATE OF BIRTH (month, day, and year) May 17-1859.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	1	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 678

(b) General nature of industry, business, or establishment in which employed (or employer) Retired Foreman.

(c) Name of employer United Railways & Elec. Co.

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Conrad Long.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany.

12 MAIDEN NAME OF MOTHER Unknown.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Mrs. John W. Colley.

(Address) 611 N. Bentalou St.

JUL 10 1929 G. H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8th 1929

17

I HEREBY CERTIFY, That I attended deceased from June 15 . 1929 . to July 8th . 1929 .

that I last saw him alive on July 8th . 1929 .

and that death occurred, on the date stated above, at 6.50 P. m.

The CAUSE OF DEATH* was as follows:

Terminal bronchopneumonia

(duration) — yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? none

(Signed) M. R. Lucas . M. D.

7/8. 1929 (Address) 3421 Edmondson Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral Cemetery	July 11- 1929.

20 UNDERTAKER ADDRESS

Charles J. Schwab. 505 N. Monroe.

GL.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47547

CERTIFICATE OF DEATH

117

E 47547

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1523 Bolton ST. 14-21 WARD)

2—FULL NAME Elizabeth Tower Frick

(a) RESIDENCE NO. 1523 Bolton ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, ~~Married, Widowed,~~ or ~~Divorced,~~ (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 6th 1860

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
69	2	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: George P. Frick

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Katherine Turnbull

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Washington D. C.

14 Informant: Ellicott & Worthington

(Address) 1531 Bolton St

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D.

Per ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 9th 1929

17 I HEREBY CERTIFY, That I attended deceased from June 20th, 1929, to July 9th, 1929, that I last saw h[illegible] alive un[illegible] June 29th, 1929, and that death occurred, on the date stated above, at 1. P m.

The CAUSE OF DEATH* was as follows:

Coronary embolism

Some

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Inoperable appendicect.

(duration) ✓ yrs. ✓ mos. 20 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? ... Date of ...

Was there an autopsy? No.

What test confirmed diagnosis? ✓

(Signed) Ed Wan Hop, M. D.

1.10. 1929 (Address) 1515 Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	July 11 1929
20 UNDERTAKER	ADDRESS
Henry Wenkin & Son Inc	Eutaw & Gold St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47548

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

44 E 47548

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) Baltimore City Hosp 4-30 (Ward)

2—FULL NAME Thomas Smith (Thomas Charlton)

(a) RESIDENCE NO. 106 Wilson Ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Mal.	Whit.	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Cora Charlton

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	66			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labour

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hospital Record
(Address)

15 Filed 1 01929 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/9/29

17 I HEREBY CERTIFY, That I attended deceased from 7/2, 1929, to 7/9, 1929, that I last saw h-[illegible] alive on 7/9, 1929 and that death occurred, on the date stated above, at 4:20 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Pylorus

(duration) Unknown ds.

CONTRIBUTORY (Secondary) Edema Lungs - Myocarditis (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of 7/8/29

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy.

(Signed) L. H. Crampton, M. D.

7/10, 1929 (Address) Balt. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Wash D C

DATE OF BURIAL 7/10 1929

20 UNDERTAKER D. Timothy Hanlon

ADDRESS Wash D C

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

Susetta Grenfield

E 47549

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

1225002

E 47549

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital W-30 Ward)

2-FULL NAME Susie Grenfield

(a) RESIDENCE NO. Pasadena, A. A. Co St. Md Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elwood Grenfield

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	55			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work At home
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Basil Constant
(Address) Hamilton Md

15 Filed JUL 1 1929 By C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Arrhosis of Liver

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Eugene Zell Jr M. D.

7-9-1929 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem — DATE OF BURIAL 7/11 1929

20 UNDERTAKER Robert Brooks & Son — ADDRESS Calhoun Hollins

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47550

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 47550

1—PLACE OF DEATH: Mercy Hospital

CITY OF BALTIMORE: (No. 6-11 ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME: John McCleary

(a) RESIDENCE NO. 127 N. Curley ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 56 yrs. 8 mos. 16 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Anna A. Hunter

6 DATE OF BIRTH (month, day, and year) Oct 23-1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	56	8	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer): Ship Building

(c) Name of employer: Bethlehem Steel Co

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Wm J McCleary

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Anna C. Coleman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto Md

14 Informant: Geo R. McCleary

(Address) 12-20 Tenderand

15 Filed JUL 10 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-9-29

17 I HEREBY CERTIFY, That I attended deceased from 7-2—, 1929, to 7-9, 1929, that I last saw him alive on 7-9, 1929 and that death occurred, on the date stated above, at 10 45 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

Cardio vascular disease with hypertension

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac decompensation

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J Leyko, M. D.

7-9, 1929 (Address) Mercy Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cem	July 12 1929

20 UNDERTAKER: Harry W. Ehlen

ADDRESS 1440 W. North Ave

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

(Mail)

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47551

CERTIFICATE OF DEATH

E 47551

REGISTERED NO. 15-61 185

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 3139 Sequoia Ave St. 15 Ward)

2-FULL NAME Mary C. Dail

(a) RESIDENCE NO. 3139 Sequoia Ave St., Ward Westminster Md

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 1 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Wm L. Dail

6 DATE OF BIRTH (month, day, and year) Nov 23-1842

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	86	7	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Cambridge Md
(State or country)

PARENTS

10 NAME OF FATHER Edw Phillips

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Mary Eaton

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Mrs Wm H. Dail
(Address) 3139 Sequoia Ave

15 Filed ..... 19..... C. HAMPSON JONES, M. D. Registrar

JL 10 1929

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) July 9th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to ..... death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(Accident) (duration) 1 da mos. ds.

CONTRIBUTORY (Secondary) Fracture Tibia

Fell down Steps (duration) yrs. mos 21 ds.

18 Where was disease contracted If not at place of death? Residence

Did an operation precede death? yes Date of July 16

Was there an autopsy? No

What test confirmed diagnosis? Regulas

(Signed) July 10 F. Blunk, M. D.

(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park Cem — DATE OF BURIAL July 1929

20 UNDERTAKER Harry W. Ellen — ADDRESS 1948 W. North Ave

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47552

CERTIFICATE OF DEATH

E 47552

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hosp. St. 13-5 Ward)

2-FULL NAME Mary E. Grant

(a) RESIDENCE NO. 2330 Penna St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 Color or Race: Col

5 Single, Married, Widowed or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: No

6 DATE OF BIRTH (month, day, and year): Dec 7-1924

7 AGE: Years 4 | Months 7 | Days | IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: None,
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town): Baltimore

(State or country):

PARENTS

10 NAME OF FATHER: Clifford Grant

11 BIRTHPLACE OF FATHER (city or town): [illegible]

(State or country):

12 MAIDEN NAME OF MOTHER: Jessie Chambers

13 BIRTHPLACE OF MOTHER (city or town): Va

(State or country):

14 Informant: Jessie Grant

(Address): 2330 Penna Ave

15 Filed 19

C. HAMPSON JONES, M. D. Registrar

By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 9th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accident
Fracture of Femur.

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Shock following operation

Fell off Swing

(duration) yrs. mos.

Where was disease contracted if not at place of death? Wonderland Park

Did an operation precede death? Yes Date of July 9th

Was there an autopsy? No

What test confirmed diagnosis? Roentgen

(Signed) F. C. Funk, M. D.

(Address) July 10th 1929 Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn

DATE OF BURIAL: July 11 1929

20 UNDERTAKER: Mrs. Geo. H. Holland

ADDRESS: 1631 Druid Hill

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JUL 10 1929

Spec.—1-12-23—M&T—500 Blks.

E 47553

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

47 E 47553

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 524 E. 21st ST., 9-46 WARD)

2-FULL NAME Rosalie D. Casey

(a) RESIDENCE NO. 524 E. 21st ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. 1 mos. 1 ds. How long in U. S., if of foreign birth? -- yrs. -- mos. -- ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank A. Casey

6 DATE OF BIRTH (month, day, and year): June 9, 1869

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	60	1	1	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Charles Kerndl

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Anna M. Brezel

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Frank A. Casey

(Address): 524 E. 21st Street

15 Filed JUL 10 1929

By [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7/10 1929

17 I HEREBY CERTIFY, That I attended deceased from May 20, 1929, to July 10, 1929, that I last saw h[illegible] alive on July 9, 1929, and that death occurred, on the date stated above, at 7 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma (Breast)

(duration) Months Days

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Yes Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. R. Goedsborough M. D.

19 (Address) 2923 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery

DATE OF BURIAL: 7/12 1929

20 UNDERTAKER: Henry H. Mears & Son

ADDRESS: 805 W. Calvert

C. HAMPSON JONES, M. D.

L 10 1929

N. B.—WHITE PAPER, WITH CARBON INK. THIS CERTIFICATE MUST BE FILLED OUT IN DUPLICATE. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47554

CERTIFICATE OF DEATH

90 E 47554

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 627 S. Patterson Pk. Ave. WARD) 1-3

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank Malecki

(a) RESIDENCE NO. 627 S Patterson Pk. AVE., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work 0+0

(b) General nature of industry, business, or establishment in which employed (or employer) Labor

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Agnes Malecka

(Address) 627 S. Patterson Pk. Ave

15 Filed JUL 10 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8 1929

17 I HEREBY CERTIFY, That I attended deceased from June 26, 1929, to July 8, 1929, that I last saw him alive on July 8, 1929, and that death occurred, on the date stated above, at 8 15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic myocarditis

(duration) yrs. unkn mos. sec.

CONTRIBUTORY (Secondary) arteriosclerosis

(duration) yrs. unkn mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Franz. Jannopta, M. D.

7/10, 1929 (Address) 246 Fairfax

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Stanislaus	July 11 1929
20 UNDERTAKER	ADDRESS
D. John M Weber	791 S Chester

IMPORTANT—Before signing, carefully examine this certificate. Not more than one cause of death should be returned on a line. Each cause must be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47555

CERTIFICATE OF DEATH

90

E 47555

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 140 N. Luzerne ave. ST. 6-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alexander Jones

(a) RESIDENCE NO. 140 N. Luzerne ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary L. Jones

6 DATE OF BIRTH (month, day, and year): June 26/1857

7 AGE: Years 72 | Months | Days 12 | If LESS than 1 day, hrs. or min. 13

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Farmer 086

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: John S. Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Margaret A. Dunnon

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Mrs. Mary L. Jones
(Address) 140 N. Luzerne

15 Filed JUL 11 1929, 19 [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 9 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 19, 1926, to July 9, 1929, that I last saw h[illegible] alive on July 9, 1929, and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Endocarditis
Mitral Regurgitation
(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) D. D. Herzog M.D. M. D.

7/10, 1929 (Address) 1205 N Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cambridge Dorchester Co Md. | DATE OF BURIAL: July 12 1929

20 UNDERTAKER: Geo. J. Herr | ADDRESS: 166 N. Luzerne ave

IMPORTANT—Before signing be certain that all items are correctly answered. Write plainly. Avoid abbreviations. Cause of DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47556

CERTIFICATE OF DEATH

E 47556

REGISTERED NO. 90

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1018 N. Patterson Park Ave. St., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Jane Robinson

(a) RESIDENCE NO. 1018 N. Patterson Park Av. St., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 78 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: James M. Robinson

6 DATE OF BIRTH (month, day, and year): Not known

7 AGE: Years 78; Months —; Days —; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Robert Hays

11 BIRTHPLACE OF FATHER (city or town) (State or country): New York

12 MAIDEN NAME OF MOTHER: Mary McDonald

13 BIRTHPLACE OF MOTHER (city or town) (State or country): New York

14 Informant: Mrs. Eva A. Trifet

(Address): 1018 N. Patterson Park Ave

15 Filed JUL 11 1929, 19 — HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 9 1929

17 I HEREBY CERTIFY, That I attended deceased from July 1, 19 29 to July 9, 19 29, that I last saw h[illegible] alive on July 8, 19 29 and that death occurred, on the date stated above, at 7 40 P. m.

The CAUSE OF DEATH* was as follows: Mitral Regurgitation

(Duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary): A cute Cardiac Dilatation

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible] M. D.

(Address) 1018 N. Patterson Park Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery — DATE OF BURIAL: July 12 1929

20 UNDERTAKER: Henry Stocki Sons Inc. — ADDRESS: 1301 E. Eager St

L 1

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47557

CERTIFICATE OF DEATH.

162 E 47557

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 773 Gengl ST. 17-26 WARD)

2-FULL NAME James Alfred Grover

(a) RESIDENCE NO. 773 Gengl ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND) of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 8, 1929

7 AGE: Years | Months | Days: one | If LESS than 1 day, hrs. or min.: 10

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Alfred Grover

11 BIRTHPLACE OF FATHER (city or town) (State or country) Accomack Co Va

12 MAIDEN NAME OF MOTHER Estelle Cox

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Accomack Co Va

14 Informant Alfred Grover

(Address) 773 Gengl St.

15 Filed JUL 11 1929 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9 1929

17 I HEREBY CERTIFY, That I attended deceased from July 8, 1929, to July 9, 1929

that I last saw h[illegible] alive on July 9, 1929

and that death occurred, on the date stated above, at 10:30 p m

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) yrs. mos 0d ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) [illegible], M. D.

, 19 (Address) 773 Gengl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL: Mt Auburn Cem. DATE OF BURIAL: July 11, 1929.

20 UNDERTAKER: Samuel T Hensley ADDRESS: 578 Biddle St.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JUL 11 1929

Spec.—2-29-28—L. F. S.—500 Bks.

E 47558

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47558

1—PLACE OF DEATH Mt Hope Retreat — REGISTERED NO. ....

CITY OF BALTIMORE: (No. .... ST. .... WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thomas J. Whalen

(a) RESIDENCE NO. .... (Usual place of abode) ST., Granite Md WARD .... (If non-resident give city or town and State)

Length of residence in city or town where death occurred — yrs. 6 mos. — ds. — How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) About 1852

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
About 77	Unknown		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) Unknown (State or country) Ireland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Ireland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Ireland

14 Informant Mt Hope Records (Address) Mt Hope Retreat

15 Filed ... 19 ... C. HAMILTON JONES, M. D. Registrar

JUL 11 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10, 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 25, 1928, to July 10, 1929, that I last saw him alive on July 9, 1929, and that death occurred, on the date stated above, at 7.20 a. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis
(Chr Myocarditis)
(Cerebral Haemorrhage)

Unknown (duration) — yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Senile Dementia

Unknown (duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of ....

Was there an autopsy? No

What test confirmed diagnosis? Physical & Chemical

(Signed) Julian P Hill, M. D.

, 19 (Address) Mt Hope Retreat

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Granite Balto Co Md	July- 1929.
20 UNDERTAKER	ADDRESS
Stewart & Co	Balto.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E· 47559

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 60-001 E 47559

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bon Secours Hospital Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Daisy T. Bond

(a) RESIDENCE NO. 1366 Franklin ST. Hagerstown Md. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced (or) WIFE of: Benjamin Bond

6 DATE OF BIRTH (month, day, and year): Oct 5. 1879

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
49	9	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Hagerstown Md

PARENTS

10 NAME OF FATHER: Lemuel H. Johnston

11 BIRTHPLACE OF FATHER (city or town) (State or country)

12 MAIDEN NAME OF MOTHER: Caroline Bowman

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant: Hospital Records (Address)

15 Filed JUL 11 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7/11 1929

17 I HEREBY CERTIFY, That I attended deceased from 5/11 1929 to 7/11 1929.

that I last saw her alive on 7/11 1929,

and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

(1) Cardiovascular-renal disease (Thyroid in origin) c (2) Acute thyrotoxicosis.

(duration) (1) 7 yrs. mos (2) 4 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. da.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagoosis? —

(Signed) Thos Estaey Jr, M. D.

, 19 (Address) Bon Secours Hosp

*State the Disease Causiog Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hagerstown, Md. DATE OF BURIAL July 11 1929

20 UNDERTAKER: J. J. Dickson & Sons ADDRESS Hagerstown

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

'E 47560

CERTIFICATE OF DEATH.

8 E 47560

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 920 N. Fulton (St.) 16 22 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frances Skinner

(a) RESIDENCE NO. 920 N. Fulton Ave ST.

(Usual place of abode) WARD

Length of residence in city or town where death occurred 30 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years: about 65 Months: — Days: — If LESS than 1 day, hrs. or min.: —

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of Industry, business, or establishment in which employed (or employer): ditto

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country): Washington Ohio

PARENTS

10 NAME OF FATHER: Telford Skinner

11 BIRTHPLACE OF FATHER (City or town) (State or country): Ohio

12 MAIDEN NAME OF MOTHER: Mary Virtue

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Balto.

14 Informant (Address): Laura A. Skinner New York City

15 Filed JUL 11 1929 J. MAMMEN JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 10 1929

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1929, to July 10, 1929, that I last saw her alive on July 10, 1929, and that death occurred, on the date stated above, at 9.45 a.m.

The CAUSE OF DEATH* was as follows:

Hypostatic Pneumonia

(duration) yrs. — mos. 5 ds.

CONTRIBUTORY (Secondary) Paralysis Agitans (duration) 2 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? X

Did an operation precede death? no Date of X

Was there an autopsy? no

What test confirmed diagnosis? none

(Signed) C. Wm. Williams M. D.

, 19 (Address) 901 Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Old Washington Ohio

DATE OF BURIAL: 7/ 1929

UNDERTAKER: Chas. E. Graul & Son

ADDRESS: 1180 W. Royal Ave

N. B.—WRITE PLAINLY, WITH INDELIBLE INK. THIS IS A PERMANENT RECORD. EVERY item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec—12-23-21—E.B.R.S.—400 Eks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47561

1-PLACE OF DEATH

CERTIFICATE OF DEATH.

E 47561

Registered No.

City of BALTIMORE: (No. 5110 York Rd St. 27th Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME. Hugh J. Gallagher

(a) Residence No. 5110 York Rd St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime ds How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Male

4-COLOR OR RACE, White

5-Single, Married, Widowed, or Divorced, (Write the word.) Married

5a-If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Nannie E. Gallagher

6-DATE OF BIRTH (month, day and year) July 24 1868

7-AGE. 60 yrs. 11 mos. 11 ds. If LESS than 1 day, hrs. or min.?

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work. Clerk

(b) General nature of industry, business, or establishment in which employed (or employer). Car Works

(c) Name of employer. City

9-BIRTHPLACE (city or town) (State or Country). Balt. Md

PARENTS.

10-NAME OF FATHER. Patrick Gallagher

11-BIRTHPLACE OF FATHER (city or town) (State or Country). Ireland

12-MAIDEN NAME OF MOTHER. Margaret Cunningham

13-BIRTHPLACE OF MOTHER (city or town) (State or Country). Ireland

14- (Informant) Nannie E. Gallagher

(Address) 5110 York Rd

15- Filed JUL 11 1929 CLARENCE JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year). July 10, 1929

17- I HEREBY CERTIFY, That I attended deceased from June 2 1929 to July 10 1929 that I last saw h. alive on July 10 1929 and that death occurred, on the date stated above, at 4:30 A. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis Chr. Nephritis

Chr. Myocarditis Edema 1 months.

(Duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senile cardiac debility

(Duration) yrs. mos. 1 ds.

18-Where was disease contracted if not at place of death? same

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) C. W. Jacobs M. D.

July 10, 1929 (Address) 50 E. Chase St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL. Loudon Park Cem. DATE OF BURIAL. July 13 1929

20-UNDERTAKER. Grace P. Francis & Son ADDRESS 1800 Monument Ave

should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 47562

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47562

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2116 Cliftwood Ave. ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lissetta Reichards

(a) RESIDENCE NO. 2116 Cliftwood Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Edmund C. Reichards

6 DATE OF BIRTH (month, day, and year) Aug. 28/58

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	10	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Ludwig W. Spies

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Eva-------

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md,

14 Informant Millard F. Piercy

(Address) 2116 Cliftwood Ave

15 Filed JUL 11 1929 H. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9/29

17 I HEREBY CERTIFY that I attended deceased from Jan 1 29 to July 9 29

that I last saw h alive on July 8 29

and that death occurred on the date stated above, at 11,05 A.M.

The CAUSE OF DEATH was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) acute Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Geo. A. Burrell M. D.

July 9 19 29 (Address) 800 N. Eutaw St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem.

DATE OF BURIAL July 11/29

20 UNDERTAKER Philip Herwig

ADDRESS 2016 Orleans St.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47563

CERTIFICATE OF DEATH

384

E 47563

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2220 Pennsylvania ST. 15-21 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jolyn Haggins

(a) RESIDENCE NO. 2220 Pennsylvania ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
m	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Sallie Haggins

6 DATE OF BIRTH (month, day, and year) — — 1887

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	42	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stone-keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) ?

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) ?

14 Informant Dora Webb

(Address) 2220 Penna Ave.

15 Filed JUL 11 1929 WILLIAM H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8. '29.

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1929, to July 8, 1929, that I last saw h— alive on July 8, 1929 and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Acute Nephritis
Acute Catarrhal Gastritis

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Uremia, Acute Myocarditis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. Exam

(Signed) William H. Haggerty M. D.

, 19 (Address) 1420 E. Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Calvary	July 11, 1929
20 UNDERTAKER	ADDRESS
Mrs. R. G. Elliott	122 Ashland Ave

Date July 11 1929

IMPORTANT—Certificate should be carefully prepared. Avoid unscientific terms. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 47564 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47564

CERTIFICATE OF DEATH.

91-002

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3053 Brighton St (ST.) 16-67 (WARD)

2-FULL NAME August Schaefer.

(a) RESIDENCE NO. 3053 Brighton, ST., WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 75 yrs. mos. ds. How long in U. S., if of foreign birth? 75 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, ~~Married~~, Widowed, or Divorced, (write the word)
Male	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 24, 1850.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	78.	8	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER August Schaefer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany.

14 Informant Miss Minnie Schaefer
(Address) 3053 Brighton St

15 Filed JUL 11 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9 1929.

17 I HEREBY CERTIFY, That I attended deceased from May 1, 1929 to July 9, 1929, that I last saw him alive on July 8, 1929 and that death occurred, on the date stated above at 5:40 p.m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis
Cystitis, Hypertrophy of Prostate (duration) Undetermined
CONTRIBUTORY (Secondary) General debility
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No —

What test confirmed diagnosis? Clinical

(Signed) M. Fillinger M. D.

(Address) 682 Park Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park. DATE OF BURIAL: 7/11/29

20 UNDERTAKER: Geo. Leimbach & Co. ADDRESS: 520 N. Lyndhurst

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47565 E 47565

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Maryland General Hospital ST.) (WARD)

2—FULL NAME Aubrey Bryan

(a) RESIDENCE NO. ~~926 Hatton Pl~~ Jones Creek Md ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	M.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Agnes Bryan

6 DATE OF BIRTH (month, day, and year) Mar 30 1898

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
31	3	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Heater in pot mill

(b) General nature of industry, business, or establishment in which employed (or employer) Beth. Steel Corp.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Texas

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital record
(Address)

15 Filed JUL 11 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/8/29

17 I HEREBY CERTIFY, That I attended deceased from 7-8, 1929, to 7-8, 1929, that I last saw him alive on 7-8, 1929 and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Heat prostration c heart failure

6 hrs duration (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Sparrows Point

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

7/8/29 (Signed) H. Hampton Jones, M. D.
(Address)

*State the Disease causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross DATE OF BURIAL July 12 1928

20 UNDERTAKER Wm F Denny ADDRESS 715 Light St

IMPORTANT—Information should be carefully supplied. Avoid abbreviations. Write plainly with pen and ink. Exact statement of OCCUPATION is very important. See instructions on back of certificates. OF DEATH in plain terms, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47566

CERTIFICATE OF DEATH.

E 47566

REGISTERED NO. 161

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL (St.) (Ward) 10-9

2-FULL NAME Virginia May Nelson

(a) RESIDENCE NO. 420 McElderry ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: f-m

4 COLOR OR RACE: black

5 Single, Married, Widowed, or Divorced, (write the word): single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7-7-29

7 AGE — Years — Months — Days: 2 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: baby

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md —

PARENTS

10 NAME OF FATHER Luther

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Records.

(Address) JOHNS HOPKINS HOSPITAL

15 Filed 7/11 1929 C. HAMPSON JONES, M. D. Registrar

By CKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-9-1929

17 I HEREBY CERTIFY, That I attended deceased from 7-9-1929. to 7-9-1929.

that I last saw her alive on 7-9-1929.

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

prematurity

7 months gestation

(duration) yrs. mos ~ ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) B. C. Goodwin, M. D.

7/10, 1929 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: HOPKINS HOSPITAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS 1929

B.—WRITE PLAINLY, WITH PENCIL OR PEN. IT IS A PENITENTIARY OFFENSE TO MAKE A FALSE STATEMENT IN ANY CERTIFICATE. PHYSICIANS should state carefully supplied. AGE should be stated EXACTLY. mation should be CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47567

HEALTH DEPARTMENT—CITY OF BALTIMORE

54

E 47567

CERTIFICATE OF DEATH

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO.

CITY OF BALTIMORE: (No. ST., 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Peter De Martin

(a) RESIDENCE NO. 1727 Lancaster ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? ? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) 1859

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	70			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) ? (State or country) Germany

PARENTS

10 NAME OF FATHER Christopher De Martin

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Germany

12 MAIDEN NAME OF MOTHER Eta ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Germany

14 Informant Records of (Address BALTIMORE CITY HOSPITALS)

15 Filed 7-11 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 26, 1929, to 7-9, 1929, that I last saw him alive on 7-9, 1929 and that death occurred, on the date stated above, at 2:50 A. m.

The CAUSE OF DEATH* was as follows:

Pellagra

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Karen M. McLean, M. D.

7-9, 1929 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	7/12 1929
20 UNDERTAKER	ADDRESS
John M Weber	401 S Chester

L 11 1929

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 47568 **HEALTH DEPARTMENT—CITY OF BALTIMORE** E 47568

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Franklin Sq. Hosp. (ST.) (WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma Durham

(a) RESIDENCE No. 2638 Frederick Ave. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred [illegible] yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John L. Durham Jr.

6 DATE OF BIRTH (month, day, and year): Sept. 2, 1892

7 AGE: Years 36 Months 9 Days 20 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Henry Livingston

11 BIRTHPLACE OF FATHER (city or town) (State or country): Maryland

12 MAIDEN NAME OF MOTHER: [illegible]

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: John L. Durham Jr.

(Address): 2638 Frederick Ave.

15 JUL 11 1929 C. HAMPSON JONES, M. D. Registrar

RKH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 11 - 1929

17 I HEREBY CERTIFY, That I attended deceased from July 9, 1929, to July 11, 1929, that I last saw her alive on July 11, 1929, and that death occurred, on the date stated above, at 3-a m.

The CAUSE OF DEATH* was as follows:

Streptococcus Septicemia

(duration) yrs. mos 8 ds.

CONTRIBUTORY (Secondary) ?

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Elimination

(Signed) Arthur Rattenni M. D.

7/11, 1929 (Address) Franklin Sq. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Arnold Ridge — DATE OF BURIAL: July 13 1929

20 UNDERTAKER: Harry L. Witzke — ADDRESS: 53 W. Lombard St.

N. B.—WHITE PLAINLY, WITH UNFADING INK. THIS IS A PERMANENT RECORD. EACH item should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

E 47569

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47569

CERTIFICATE OF DEATH

1-PLACE OF DEATH The Children's Hospital School

CITY OF BALTIMORE: (No. Greenspring Ave & 41st St.) (WARD) 13-27

REGISTERED No. C

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Frances Ile Buss

(Residence in Baltimore: No. Owings Mills, Md St.; yrs., 2 mos. ds.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. Female

4-COLOR OR RACE. White

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED. (Write the word.) Single

6-DATE OF BIRTH. April 4th, 1918. (Month) (Day) (Year)

7-AGE. 11 yrs. 2 mos. 17 ds. If LESS than 1 day, hrs. or min.? 3 7

8-OCCUPATION:
(a) Trade, profession, or particular kind of work School child
(b) General nature of industry, business, or establishment in which employed (or employer) —

9-BIRTHPLACE. (State or Country). Owings Mills, Md

PARENTS.

10-NAME OF FATHER. Adam Ile Buss

11-BIRTHPLACE OF FATHER (State or Country). Maryland

12-MAIDEN NAME OF MOTHER Fannie Schaefer

13-BIRTHPLACE OF MOTHER (State or Country). Maryland

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) J. Frank Hewitt M.D.

(Address) The Children's Hospital School

15-

Filed ..... 191.....

C. HAMPSON JONES, M.D. Registrar.

Per .....

L 11 1929

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH. July 11, 1929. (Month) (Day) (Year)

17. I HEREBY CERTIFY, That I attended deceased from May 1 1929, to July 11 1929, that I saw h m alive on July 11 1929, and that death occurred, on the date stated above, at 5.40 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of lumbar and sacral vertebrae, left ilium, hip and upper femur and amyloidosis and anasarca

(Duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis

(Duration) yrs. 2 mos. ds.

(Signed) J. Frank Hewitt M. D.

July 11 1929 (Address) The Children's Hospital School

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (For HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 1 yrs. 11 mos. 27 ds. In the State 16 yrs. 2 mos. 17 ds.

Where was disease contracted, if not at place of death? At Home

Former or usual residence Owings Mills, Md

19-PLACE OF BURIAL OR REMOVAL. St Thomas Cemetery DATE OF BURIAL. July 13, 1929

20-UNDERTAKER J. F. Elsie ADDRESS Reisterstown Md

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should give CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47570

1942 E 47570

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Franklin Sq Hospital 10-27 Ward

2-FULL NAME John W. Ritter

(a) RESIDENCE NO. 328 N. Payson St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed or Divorced (write the word): Widowed

5a If married, widowed, or divorced — HUSBAND of (or) WIFE of: Hannah Ritter

6 DATE OF BIRTH (month, day, and year): Nov 25 1858

7 AGE — Years: 70 Months: 8 Days: 4 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town):
(State or country): Balto Md

PARENTS

10 NAME OF FATHER: John Ritter

11 BIRTHPLACE OF FATHER (city or town):
(State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town):
(State or country): Germany

14 Informant: Mrs E Sivan
(Address) 327 N. Payson St

15 Filed 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 7 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Eczema Lat

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Charles Brooke M. D.

7 19 29 (Address) 3601 [illegible]

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: LOUDON PARK CEMETERY — DATE OF BURIAL: July 12 1929

20 UNDERTAKER: F. WIPPERT — ADDRESS: 1850 W. BALTIMORE ST

JUL 11 1929

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47571 CERTIFICATE OF DEATH 129 **E 47571**

1—PLACE OF DEATH REGISTERED NO. 12-51

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 408 E. 23rd St. ST. WARD)

2—FULL NAME Daniel B. Moore

(a) RESIDENCE NO. 408 E. 23rd St. ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Margaret L. Moore

6 DATE OF BIRTH (month, day, and year) Jan. 15-1882

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	47	5	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stationary Engineer

(b) General nature of industry, business, or establishment in which employed (or employer) 030

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Edmund B. Moore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Elind Hallman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pennsylvania

14 Informant Mrs. Margaret L. Moore
(Address) 408 E. 23rd St.

15 Filed ..... 19 ..... HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10-1929

17 I HEREBY CERTIFY, That I attended deceased from July 19- 19 28 to July 10 19 29

that I last saw him alive on July 9- 19 29.

and that death occurred, on the date stated above, at 1.30 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral arteriosclerosis, hypertension, and Chronic nephritis.

(duration) 1 yr. 4 mos. 21 ds. (3rd stroke)

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) George A Bowden, M. D.

7/11 19 29 (Address) 1817 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Grace Cemetery Chestnut Ridge Balto. Co. DATE OF BURIAL July 13 19 29

20 UNDERTAKER Horace H. Burgee ADDRESS 363 Falls Road

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION necessary important. See instructions on back of certificates.

JUL 11 1929

Spec.—2-29-28—L. F. S.—506 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47572

CERTIFICATE OF DEATH

+ 90

√# 47572

E 47572

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 4-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles W. Pruitt

(a) RESIDENCE NO. Tangier, Virginia ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Olivia Pruitt

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Waterman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant University Hospital Records

(Address)

15 Filed 19 C. HAMILTON JONES, M. Registrar

JUL 12 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-11-29

17

I HEREBY CERTIFY, That I attended deceased from July 4 . 1929 . to July 11 . 1929 . that I last saw h live on July 11 . 1929 and that death occurred, on the date stated above, at 3.00 A m.

The CAUSE OF DEATH* was as follows:

Mitral Stenosis; Paroxysmal Tachycardia; Auricular fibrillation

(duration) yrs. 7 mos. 11 ds.

CONTRIBUTORY (Secondary) Ventricular Fibrillation

(duration) yrs. Two seconds mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Lewis P. Yeandry, M. D.

7-11-1929 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Tangier, Va.	July 13 1929

20 UNDERTAKER John A. Bradshaw ADDRESS Crisfield Md

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47573

1-PLACE OF DEATH

City of Baltimore: (No. 528 W. Cross St. St. 21-21 Ward)

2-FULL NAME James Sanders Wright.(C)

(a) RESIDENCE NO. 528 W. Cross St. St., Ward
(Usual place of abode)

Length of residence in city or town where death occurred 16 yrs. --- mos. --- ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

94001

E 47573

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) January 21, 1902

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	27	5	18	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Kent Island, Md.
(State or country)

PARENTS

10 NAME OF FATHER Daniel Wright.(C)

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Mary Whitcoe.(C)

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland.

14 Informant Mary Wright.(C) mother.
(Address) 523 W. Cross St.

15 Filed ... 19... C. HARRISON JONES, M. D.
Registrar

JUL 12 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9, 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage.
Hemiplegia.

(duration) yrs. mos. ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Bridgeton, N. J. 7/8/29

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirm diagnosis? Inquiry

(Signed) Otto M. Steinhardt, M. D.

7/11, 1929 (Address) 9017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 BURIAL, CREMATION OR REMOVAL Kent Island Md

DATE OF BURIAL 7-12 1929

20 UNDERTAKER Dent & Easton

ADDRESS 916 Dan

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

226915

E 47574

E 47574

CERTIFICATE OF DEATH.

37-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL (ST.) 4-26 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Longo Beaver

(a) RESIDENCE NO. 219 Myrtle Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs mos ds. How long in U. S., if of foreign birth? yrs mos ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 COLOR OR RACE: Black

5 Single, Married, Widowed, or Divorced, (write the word)

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 2/3/25

7 AGE — Years: 4 — Months: 5 — Days: 8 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Longo Beaver

11 BIRTHPLACE OF FATHER (city or town) (State or country): N. C.

12 MAIDEN NAME OF MOTHER: Adella Harrison

13 BIRTHPLACE OF MOTHER (city or town) (State or country): N C

14 Informant: Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed JUL 12 1929 19 Per C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-11-1929

17 I HEREBY CERTIFY That I attended deceased from 7-5-1929 to 7-11-1929

that I last saw him alive on 7-11-1929

and that death occurred, on the date stated above, at 8 A. m.

The CAUSE OF DEATH* was as follows:

Tuberculous Meningitis

(duration) yrs. mos 21 ds.

CONTRIBUTORY (Secondary) Miliary TB

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home? No hist. of exp.

Did an operation precede death? no Date of

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) J. C. Goodwin M. D.

1/1 1929 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem

DATE OF BURIAL: 7-12 1929

20 UNDERTAKER: Dennis Everson

ADDRESS: Penna Ave

WARNING.—WRITE PLAINLY, WITH CARBON INK. THIS BLANK IS PREPARED IN DUPLICATE, EXACT duplication should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

101-001

CERTIFICATE OF DEATH

E 47575

1—PLACE OF DEATH

REGISTERED NO. E 47575

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: No. 403 Lewis ST. 58 (WARD)

2—FULL NAME Myrtle Carter

(a) RESIDENCE NO. 403 Lewis ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	single

a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1900

7 AGE	Years	Months	Days	If LESS than 1 day... hrs. or ... min.
	29			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Raymond Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Elizabeth Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Raymond Carter

(Address) 403½ Lewis St

15 Filed JUL 12 1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10 1929

17 I HEREBY CERTIFY, That I attended deceased from July 3 1929, to July 10, 1929, that I last saw h[illegible] alive on July 9, 1929, and that death occurred, on the date stated above, at 3 m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Pulmonary Oedema

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R J Gantry, M. D.

, 19 (Address) 1429 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cem Bur — DATE OF BURIAL 7-12 1929

20 UNDERTAKER Dent & Ewing — ADDRESS 916 E Fay

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47576

CERTIFICATE OF DEATH

E 47576

REGISTERED NO.

1—PLACE OF DEATH

BALTIMORE CITY HOSPITALS

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. ? ST. 21-29 WARD)

2—FULL NAME James, Taylor

(a) RESIDENCE NO. 234 S. Fremont Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? — yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Negro	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	30 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) ? Md.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) ?

12 MAIDEN NAME OF MOTHER Mary ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) ?

14 Informant Records of (Address) BALTIMORE CITY HOSPITALS

15 Filed JUL 12 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 9, 1929

17 I HEREBY CERTIFY, That I attended deceased from 8-31, 1927, to 7-9, 1929, that I last saw him alive on 7-9, 1929 and that death occurred, on the date stated above, at 12 N.

The CAUSE OF DEATH* was as follows:

Disseminated Sclerosis

(duration) 7 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cystitis

(duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Phys. Exam. : Lab.

(Signed) Marvin M. McLean, M. D.

7-10, 1929 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Zion Cemetery

UNDERTAKER Mrs. Katie R. Williams

DATE OF BURIAL July 13, 1929

ADDRESS 3224 Schroeder St

IMPORTANT—Before signing, read carefully. Be sure that every item is correct and complete. Make no erasures. Any false statement, omission or concealment of facts may subject the informant to prosecution. Write plainly with pen and ink and use common terms. Give usual residence of deceased, even though death occurred elsewhere. Be sure to answer every question. If unknown, say so. Do not refer to any other certificate or schedule. Do not state cause of death in terms of mode of dying, such as heart failure, asthenia, etc., but state the disease causing such failure. Indefinite and unsatisfactory causes of death will be returned for correction. Certificate of birth should be obtained in all cases. Cause of death must be certified to the best knowledge and belief of the undersigned. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47577

CERTIFICATE OF DEATH

E 47577
REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Balto. City Hosp. ST., (or) WARD)

2—FULL NAME Elizabeth Hansen (HANSEN.)

(a) RESIDENCE NO. 6735 O'Donnell ST., 26 WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elmer Hansen

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	38	1	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Salem Co. New Jersey

PARENTS

10 NAME OF FATHER David Hopman

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Jersey

12 MAIDEN NAME OF MOTHER Mary Loper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New Jersey

14 Informant Chas. Hansen Hosp. Records

(Address) 6735 O'Donnell Ave

15 Filed JUL 12 1929, 19 G. HAMPTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/11/29

17 I HEREBY CERTIFY, That I attended deceased from 6/18, 1929, to 7/11, 1929, that I last saw h e alive on 7/11, 1929 and that death occurred, on the date stated above, at 12 M. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

Left tubo ovarian abscess

Right Pyo salpinx

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of 7/5/29

Was there an autopsy? No

What test confirmed diagnosis? Operation - Clinical

(Signed) Lillie L. Lumpkin, M. D.

7/11, 1929 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Fairview Cem. Dundalk	July 14 1929
20 UNDERTAKER Zile + Miller	ADDRESS 40 W. Lex. St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47578 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47578

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1218 N. Caroline St. 10-13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ignatius Libertini

(a) RESIDENCE NO. 1218 N. Caroline St. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Genestata Libertini

6 DATE OF BIRTH (month, day, and year) Dec 8 1876

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
53	52	6.	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Italy.

PARENTS

10 NAME OF FATHER James Libertini

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy.

12 MAIDEN NAME OF MOTHER L. Josephine

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy.

14 Informant Michael Libertini

(Address) 1218 N. Caroline St.

15 Filed JUL 12 1929 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/10/29

17 I HEREBY CERTIFY, That I attended deceased from 7-8-, 19 29, to 7-10-, 19 29

that I last saw h alive on 7-10-, 19 29

and that death occurred, on the date stated above, at 7 P. m.

The CAUSE OF DEATH* was as follows:

Coronary Thrombosis.

CONTRIBUTORY (Secondary) Cardiac Insufficiency (duration) yrs. mos. 3 ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? What test confirmed diagnosis? Clinical examination

(Signed) Dr. F. Creech M. D.

, 19 (Address) 811 Scott

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Vincent Cemetery	July 13 1929
20 UNDERTAKER	ADDRESS
Leon L. Ruth	1735 Hanford

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Pinto Presbyterian St. Paul

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47579

CERTIFICATE OF DEATH

E 47579

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1736 Braddish Ave ST. 15-60 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Dennis A Riley

(a) RESIDENCE NO. 1736 Braddish Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

6a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year): Aug. 30, 1869

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
59	10	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Spiritual Medium

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Self.

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: John Riley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Carter

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Charles Sears

(Address) 1736 Braddish Ave.

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 11 1929

17 I HEREBY CERTIFY, That I attended deceased from July 3 - 1929, to July 11 1929, that I last saw h[illegible] alive on July 9, 1929 and that death occurred, on the date stated above, at 9 a.m.

The CAUSE OF DEATH* was as follows:

Valvular Disease, Cardiac, Chronic

CONTRIBUTORY (Secondary) Cholecystitis, acute (duration) yrs. 4 mos. ds.

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical signs

(Signed) H W Pinto, M. D.

7-11, 1929 (Address) 1302 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
N.E. Poplar Grove Church	July 13 1929
20 UNDERTAKER	ADDRESS
Wm Cook	1217 St Paul St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 47580 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47580

CERTIFICATE OF DEATH. 120

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. 13-59 (WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Melchior Jacobsen

(a) RESIDENCE No. 2526 Druid Pk Drive ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. 6 mos. ds. How long in U. S., if of foreign birth? unknown mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Augusta

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Printer ?

(b) General nature of industry, business, or establishment in which employed (or employer) unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Carsten

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Louise Johannesen

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUL 12 1929, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 8 1929

17 I HEREBY CERTIFY, That I attended deceased from June 27. 1929. to July 8. 1929.

That I last saw him alive on July 8. 1929.

and that death occurred, on the date stated above, at 245 A m.

The CAUSE OF DEATH* was as follows:

Acute yellow atrophy of liver

? (duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary) Acute

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis? Autopsy.

(Signed) James Bradley III M. D.

7-8. 1929 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet DATE OF BURIAL 7/12 1929

20 UNDERTAKER Wm Cook ADDRESS 1217 E Fayette

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JUL 12 1929

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47581

CERTIFICATE OF DEATH

E 47581

REGISTERED NO.

1-PLACE OF DEATH Jenkins Memorial Hospital

City of BALTIMORE: (No. 1000 Caton Ave St. 10-15 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mary Norton

(a) RESIDENCE NO. 618 East Eager St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 27, 1863

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min..
	65	6	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) Baltimore Md

(State or country)

PARENTS

10 NAME OF FATHER Michael Beatty

11 BIRTHPLACE OF FATHER (City or town) Ireland

(State or country)

12 MAIDEN NAME OF MOTHER Anne Kelly

13 BIRTHPLACE OF MOTHER (city or town) Ireland

(State or country)

14 Informant Anne McCarthy

(Address) 420 E Biddle St

15 Filed ..., 19 ... Registrar

AUG 12 1929 C. HAMPSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10 1929

17 I HEREBY CERTIFY, That I attended deceased from 5-8, 1929, to 7-10, 1929, that I last saw h.. alive on 7-10, 1929, and that death occurred, on the date stated above, at 3:30 P m.

The CAUSE OF DEATH* was as follows:

carcinoma of uterus (cervix)

(duration) ... yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Nicholas K. Donelle, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Cathedral

Date of Burial 7/13 1929

20 UNDERTAKER W. Cook

ADDRESS 1217 E Lond St

N. B.—WRITE PLAINLY, WITH INDELIBLE INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

Rack.

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 47582

E 47582

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH West Baltimore Gen. Hospital

CITY OF BALTIMORE: (No. Paeke) ST. 15-61 WARD)

2-FULL NAME William F. (Beatte) Beatte

(a) RESIDENCE No. 2923 W. North ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	White	(Widower) Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of (Louise Paeke) Unknown

6 DATE OF BIRTH (month, day, and year) JULY 1, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	8	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Theodore (Beatte) Paeke

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF ~~MOTHER~~ Emma Spangenberg

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant 2923 W. North (Address) Wm E Beatte

15 Filed JUL 12 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-10 1929

17

I HEREBY CERTIFY, That I attended deceased from June 4, 1929, to July 10, 1929,

that I last saw h in alive on July 10, 1929

and that death occurred, on the date stated above, at 5:40 P m.

The CAUSE OF DEATH* was as follows:

Prostatectomy Suprapubic

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Uraemia & Chronic

Mg. Prostatic (duration) yrs. mos. 6 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of June 15-1929

Was there an autopsy? Yes

What test confirmed diagnosis? Physical by - History - Blood tests.

(Signed) [illegible], M. D.

, 19 (Address) W. Balto. Gen. Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western

DATE OF BURIAL 7/13 1929

20 UNDERTAKER W. M. Cook

ADDRESS 1217 E Pratt St

Spec.—2-29-28—L. F. S.—500 Bks.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

E 47583

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

Dr Ingram 2439 N Wales

100 20

REGISTERED NO. E 47583

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 526 East 23rd ST., (WARD) 9-46

2—FULL NAME Mary A Harnett

(a) RESIDENCE NO. 526 East 23rd ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

6a If married, widowed or divorced (or) WIFE of: James

6 DATE OF BIRTH (month, day, and year): Nov 17, 1849

7 AGE: Years 79 | Months 7 | Days 23 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At Home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Dorchester Co Md

PARENTS

10 NAME OF FATHER: William Higgins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Dorchester Co Md

12 MAIDEN NAME OF MOTHER: Julia Donell

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Virginia

14 Informant: Mary A Brunner

(Address) 526 23rd St

JUL 12 1929

19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 10-29

17 I HEREBY CERTIFY, That I attended deceased from July 4, 1929, to July 10, 1929, that I last saw her alive on July 9, 1929 and that death occurred, on the date stated above, at 7 A m.

The CAUSE OF DEATH* was as follows:

Myocardial insufficiency

(duration) 2 yrs. mos. 2 ds.

CONTRIBUTORY (Secondary): Myocardial degeneration

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Ingram, M. D.

, 19 (Address) 2439 N. Wales St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge

DATE OF BURIAL: 7/12 1929

20 UNDERTAKER: Wm Cook

ADDRESS: 1217 St Paul

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47584

CERTIFICATE OF DEATH.

E 47584

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hospital ST. 15-58 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Solomon Adalman

(a) RESIDENCE NO. 2330 Kate Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 32 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of: Jeane Adalman

6 DATE OF BIRTH (month, day, and year): Sept 11-1895

7 AGE: Years 33 Months 10 Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Newspaper Distributer

(b) General nature of industry, business, or establishment in which employed (or employer): for The Balto Sun

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Hyman Adalman

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Dora Rashman

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: David Perlman

(Address): 4623 Park Heights Ave

15 Date Received: JUL 12 1929

C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7/11 1929

17 I HEREBY CERTIFY, That I attended deceased from June 29, 1929, to July 11, 1929, that I last saw h[illegible] alive on July 11, 1929, and that death occurred, on the date stated above, at 10 50 A. m.

The CAUSE OF DEATH* was as follows:

Heart failure

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of July 6, 1929

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. E. Brodman M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Friendship Cem. DATE OF BURIAL: July 12 1929

20 UNDERTAKER: Jack Lewis ADDRESS: 1439 E Balto St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Shabek.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47585

CERTIFICATE OF DEATH

46

E 47585

1—PLACE OF DEATH St Joseph's Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Caroline & Eager ST., 5 WARD)

2—FULL NAME Julia A. Shabek

(a) RESIDENCE NO. 2026 E Hoffman ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. 10 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James C Shabek

6 DATE OF BIRTH (month, day, and year) Sept 11, 1881

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
47	10		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Dennis Cronin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Catherine Driscoll

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mary Heine

(Address) 1736 E Fayette st

15 Filed JUL 12 1929, 19 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-11-29.

17 I HEREBY CERTIFY, That I attended deceased from 6-24-29, 19..., to 7-11-29, 19..., that I last saw h alive on 7-11-29, 19..., and that death occurred, on the date stated above, at 5P m.

The CAUSE OF DEATH* was as follows:

Cancer of uterus

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uremia

(duration) yrs. mos 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of None

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) J B Hendrix, M. D.

19 (Address) Jews Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL July 15, 1929

20 UNDERTAKER Frank V. Pipitone — ADDRESS 2515 E. Balto st

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47586

CERTIFICATE OF DEATH.

+ 19 E 47586

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 901 Ausquith (St.) 10-14 (WARD)

2-FULL NAME Sr. Mary Thomasa Hamma

(a) RESIDENCE NO. School Sisters of Notre Dame St. WARD N. Y.
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 14 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 24 1875

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
54 53		7	17 13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Teacher 068

(b) General nature of industry, business, or establishment in which employed (or employer) Religious

(c) Name of employer

9 BIRTHPLACE (city or town) N. Y. City
(State or country)

PARENTS

10 NAME OF FATHER Charles Hamma

11 BIRTHPLACE OF FATHER (city or town) N. Y. C
(State or country)

12 MAIDEN NAME OF MOTHER Mary Transnack

13 BIRTHPLACE OF MOTHER (city or town) N. Y. C.
(State or country)

14 Informant Sisters of Notre Dame
(Address)

15 July 11 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11 1929

17 I HEREBY CERTIFY, That I attended deceased from July 7 1929 to July 11 1929

that I last saw her alive on July 11 1929

and that death occurred, on the date stated above, at 9.35 a.m. m.

The CAUSE OF DEATH* was as follows:

Acute dilatation heart
Heat ex hemiplegia

(duration) yrs. mos 5 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Usual ones

(Signed) F. J. Kirby M. D.

7/12 1929 (Address) 110 E North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Rock Cliff Md — DATE OF BURIAL July 13 1929

20 UNDERTAKER Frank A. Tinch — ADDRESS 919 N. Gay St

L 12 1929

WHITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47587

CERTIFICATE OF DEATH

101-001

REGISTERED NO. E 47587

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Hosp St. 10-15 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Agnes Sullivan

(a) RESIDENCE NO. 914 Greenmount Ave. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 60 yrs. 2 mos. 6 ds. How long in U. S., If foreign birth 60 yrs. 2 mos. 6 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) May 5th 1869

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
60	2	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md. (Balto)

PARENTS

10 NAME OF FATHER Dennis Sullivan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Scully

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Mayer Friedfeld

(Address) 914 Greenmount Ave

15 Filed JUL 12 1929, 19 [illegible] Registrar

H. HANSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/11/29

17 I HEREBY CERTIFY, That I attended deceased from 7/8, 1929, to 7/11, 1929

that I last saw h[illegible] alive on 7/11, 1929

and that death occurred, on the date stated above, at 3.25 P. m.

The CAUSE OF DEATH* was as follows:

R L Lobar pneumonia

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Mental Disease

(duration) 12 yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Tuberculosis

(Signed) Truman P. Gilbert M. D.

. 19 (Address) 33 W. Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral Cemetery — DATE OF BURIAL: July 13 1929

20 UNDERTAKER: Edward W. Young — ADDRESS: Balto

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47588

CERTIFICATE OF DEATH

88 E 47588

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. 15-21 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Carrie Sampson

(a) RESIDENCE NO. 1410 School ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., If foreign birth? — yrs. — mos. — ds.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): ? Virginia

PARENTS

10 NAME OF FATHER: Thomas Watson

11 BIRTHPLACE OF FATHER (city or town) (State or country): ? Virginia

12 MAIDEN NAME OF MOTHER: Cornelia ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ? Virginia

14 Informant: Records of

(Address) Baltimore City Hospitals

15 Filed JUL 12 1929 19 H. A. Kelly Registrar

JUL 12 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 11, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1929 to July 11, 1929

that I last saw her alive on July 11, 1929

and that death occurred, on the date stated above, at 12:05 A.m.

The CAUSE OF DEATH* was as follows:

Myocarditis, acute, c dilatation

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Circulatory disturbance c

Locomotor (duration) 45 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Harvin W. McLean, M. D.

7-11-1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: PUBLIC CEMETERY

DATE OF BURIAL: JUL 12 1929 19

20 UNDERTAKER: Commissioner of Health.

ADDRESS

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47589

31 E 47589

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 4304 Belair Road ST. 27-41 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Joeckel

(a) RESIDENCE NO. 4304 Belair Road ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. 8 mos. 18 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Louise Joeckel

6 DATE OF BIRTH (month, day, and year) Oct 23rd 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	50	8	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Woollen Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER George Joeckel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Barbara Hefner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Louise Joeckel

(Address) 4304 Belair Road

15 Filed 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11th 1929

17

I HEREBY CERTIFY, That I attended deceased from 1927, 19..., to July 11, 1929

that I last saw h— alive on July 11, 1929

and that death occurred, on the date stated above, at 4:30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Kyle W. Galley, M. D.

, 19 (Address) 4103 Harford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore Cemetery	July 16th 1929

20 UNDERTAKER ADDRESS

George Schilling Sons & Co

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

L 12 1929

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47590

CERTIFICATE OF DEATH

90 E 47590

1—PLACE OF DEATH

REGISTERED NO. 20-11

CITY OF BALTIMORE: (No. 248 S Monastery ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ellen M Melville

(a) RESIDENCE NO. 248 S Monastery ST.. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., if foreign birth 60 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Widow

a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank J Melville

6 DATE OF BIRTH (month, day, and year): Mch 10 1864

7 AGE: Years 65 | Months 4 | Days 1 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER: Patrick Rafferty

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary Carey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Miss Hilda Schweikert

(Address) 248 S Monastery

15 Filed JUL 12 1929, 19

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 10th 1929

17 I HEREBY CERTIFY, That I attended deceased from April, 1929, to July 9th, 1929, that I last saw h[illegible] alive on July 7th 1929 and that death occurred, on the date stated above, at 2 a m.

The CAUSE OF DEATH* was as follows:

Oedema of Lungs

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Cardiac decompensation

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) William Dressich, M. D.

1929 19 (Address) 1700 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem	7/13/29
UNDERTAKER	ADDRESS
George A Tailby	Linthicum Heights

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION important. See instructions on back of certificates.

L 12 1929

Spec.—12-9-25—A Co.—200 Bks.

E 47591

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 47591

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 3950 Elm Ave. Ward) 13-52

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles J. Gildenfenney,

(a) RESIDENCE NO. 3950 Elm ave. St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred ~~Life~~ 60 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Florence Gildenfenney

6 DATE OF BIRTH (month, day, and year): Aug 25th 1867,

7 AGE — Years: 61 — Months: 10 — Days: 16 — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Plumber

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town): Philadelphia

(State or country): Pa

PARENTS

10 NAME OF FATHER: Chas J. Gildenfenney

11 BIRTHPLACE OF FATHER (city or town):

(State or country): Penna

12 MAIDEN NAME OF MOTHER: Maria Hard.

13 BIRTHPLACE OF MOTHER (city or town):

(State or country): Ireland.

14 Informant: Mrs Florence Gildenfenney

(Address): 3950 Elm Ave.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 9, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 3, 1929, to July 9, 1929, that I last saw ~~him~~ alive on July 9, 1929, and that death occurred, on the date stated above, at 5:50 p.m.

The CAUSE OF DEATH* was as follows:

Cardiac Dilatation

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary): Myocarditis

(duration) 2 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) Frank Hurach, M. D.

, 19 (Address) 4037 Falls Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — Date of Burial: 7/13 1929,

20 UNDERTAKER: Liston P. Fuss & Haugh — ADDRESS: 2620 St Paul

JUL 12 1929

G. HAMPSON JONES, M. D. Registrar

By

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

Peter Johns ✓

E 47592 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47592

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH U.S. Marine Hospital,

CITY OF BALTIMORE: (No. Baltimore, Md. ST 2-4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Peter Johns

(a) RESIDENCE NO. 1630 Shakespeare ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if of foreign birth? 24 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Elle Johns

6 DATE OF BIRTH (month, day, and year) Jan. 1, 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	42	6	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Seaman

(b) General nature of industry, business, or establishment in which employed (or employer) Seaman

(c) Name of employer Tug "Transfer"

9 BIRTHPLACE (city or town) (State or country) Greece

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Greece

12 MAIDEN NAME OF MOTHER Mary (?)

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Greece

14 Informant Records, U.S. Marine Hospital (Address) Baltimore, Md.

15 JUL 12 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 1929

17 I HEREBY CERTIFY, That I attended deceased from June 13 19 29 to July 12 19 29

that I last saw him alive on July 12 19 29

and that death occurred, on the date stated above, at 5:45 A m.

The CAUSE OF DEATH* was as follows:

Tuberculosis, pulmonary, active

(duration) 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? X-ray & lab. findings

(Signed) [signature] M. D.

7/12 19 29 (Address) U.S. Marine Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery

DATE OF BURIAL July 15 1929

20 UNDERTAKER Henry Sander & Sons Inc

ADDRESS Baltimore St & Broadway

INSTRUCTIONS: This certificate should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should indicate CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 47593 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 E 47593

1-PLACE OF DEATH

CITY OF BALTIMORE. (No. 2906 Grindon Ave. ST. 27-44 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Martha A. Miller

(a) RESIDENCE. NO. 2906 Grindon Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 81 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Leonard D. Miller

6 DATE OF BIRTH (month, day, and year) Dec 1st 1847

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	81	7	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Not Given

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not Given

12 MAIDEN NAME OF MOTHER Not Given

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not Given

14 Informant Mrs Elizabeth Nitt (Address) 2906 Grindon Ave

15 Filed 19 Per C. HAMPSON JONES, M. D. Registrar

JUL 12 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 1929

17 I HEREBY CERTIFY, That I attended deceased from May 7th, 1929, to July 12th, 1929, that I last saw h[illegible] alive on July 10th, 1929, and that death occurred, on the date stated above, at 1 a. m.

The CAUSE OF DEATH* was as follows:

Carcinoma Stomach

Contributory Hypostasis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostasis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

July 12, 1929 (Address) 1501 Eager St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL July 15 1929

20 UNDERTAKER Geo M. Fairchild Son — ADDRESS 811 W Cold

Information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47594

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129

E 47594

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) South Baltimore General Hospital

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Regina Gebhard

(a) RESIDENCE NO. 3145 Elmore Ave St.

(Usual place of abode)

WARD

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry C. Gebhard

6 DATE OF BIRTH (month, day, and year) Feb 8. 1890

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
39	39	5	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Louis Link

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Regina Link

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Harry C Gebhard

(Address) 3145 Elmore Ave

15 7 12 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-12-29

17 I HEREBY CERTIFY, That I attended deceased from 4-10 1929 to 7-12 1929

that I last saw her alive on 7-12 1929

and that death occurred, on the date stated above, at 10.40 A. m.

The CAUSE OF DEATH* was as follows:

Uremia

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Tests.

(Signed) Joseph B. Laukaitis, M. D.

19 (Address) South Baltimore General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore

DATE OF BURIAL 7/15 1929

20 UNDERTAKER W. M. Cook

ADDRESS 1217 E Pratt St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47595 — E 47595

CERTIFICATE OF DEATH

REGISTERED NO. 90

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 702 Pacific ST., 13-57 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Nonie Pritchett

(a) RESIDENCE NO. 702 Pacific ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of John Pritchett

6 DATE OF BIRTH (month, day, and year) Sept. 1. 1861

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	67	10	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER William Carter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Margaret Smoley

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mrs Ruth Buckler

(Address) 702 Pacific St

15 Filed JUL 2 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11, 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec 1 19 29 to July 11 19 29

that I last saw her alive on July 11 19 29

and that death occurred, on the date stated above, at 4:40 P m.

The CAUSE OF DEATH* was as follows:

Chr. Endocarditis and Myocarditis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Asthenia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical diagnosis

(Signed) J. S. Culbertson M. D.

7-12 1929 (Address) 1901 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pikesville — DATE OF BURIAL 7/12 19 29

20 UNDERTAKER J. H. Cook — ADDRESS 1217 E Fond St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 47596

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 47596

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2117 W. McCulloh ST. 23 WARD

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Ellen Carvill

(a) RESIDENCE NO. 2117 W. McCulloh ST., 23 WARD .....
(Usual place of abode)

Length of residence in city or town where death occurred 68 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Martin Carvill

6 DATE OF BIRTH (month, day, and year): Jan 18 1861

7 AGE — Years: 68 | Months: 5 | Days: 25 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Retired
(b) General nature of industry, business, or establishment in which employed (or employer): Home
(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md Baltimore

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs. Gilmore
(Address) 2117 W. McCulloh

15 Filed ..... 19 ..... Per ..... Registrar

G. HAMPSON JONES, M. D.

12 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 10 1929

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1929 to July 10, 1929
that I last saw h alive on July 10, 1929
and that death occurred, on the date stated above, at 10 P m.
The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach
Metastasis
(duration) ..... yrs. ..... mos ..... ds.

CONTRIBUTORY (Secondary) Exhaustion
(duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Clinically

(Signed) H. R. Campbell M. D.

(Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Patricks — DATE OF BURIAL: 7/13 1929

20 UNDERTAKER: Wm. Cook — ADDRESS: 1217 E Fond St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47597

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47597

REGISTERED NO.

1—PLACE OF DEATH University Parkway 840 W 34th St

CITY OF BALTIMORE: (No.) Tudor Hall Apt ST., 13-44 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph L. Downes

(a) RESIDENCE NO. Tudor Hall Apt ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single~~, Married, ~~Widowed~~, or ~~Divorced~~, (write the word): Married

5a If married, ~~widowed, or divorced~~ HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Feb 17 1859

7 AGE — Years: 70 | Months: 6 | Days: | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Insurance

(b) General nature of industry, business, or establishment in which employed (or employer): Broker

(c) Name of employer: Same

9 BIRTHPLACE (city or town) (State or country): Centreville Md.

PARENTS

10 NAME OF FATHER: John H. Downes

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Sarah ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Queen Annes Co Md

14 Informant: Ellen H Downes

(Address) Tudor Hall Apt

15 Filed ..... 19..... C. HAMPSON JONES, M. D. Registrar

JUL 12 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept 4, 1924 to July 12, 1929, that I last saw him alive on July 11, 1929 and that death occurred, on the date stated above, at 5:30 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Hend Rowe M. D.

July 12, 1929 (Address) 1115 St Paul St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lorraine Cemetery — DATE OF BURIAL: July 13 1929

20 UNDERTAKER: Henry Heuberger & Sons Co — ADDRESS: Cathedral & Mt. Vernon Pl

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47598

CERTIFICATE OF DEATH

E 47598

1—PLACE OF DEATH

REGISTERED NO. 194

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 516 Cathedral ST. 11-25 WARD)

2—FULL NAME James J. Rees.

(a) RESIDENCE NO. 516 Cathedral ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 66 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Sarah L. Rees

6 DATE OF BIRTH (month, day, and year) Aug. 31-1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	75	10	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Commission Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Retired 045

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Kent Co. Md.

PARENTS

10 NAME OF FATHER Abel J. Rees

11 BIRTHPLACE OF FATHER (city or town) (State or country) Del.

12 MAIDEN NAME OF MOTHER Lucy Short

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Kent Co. Md

14 Informant Sarah L. Rees.

(Address) 516 Cathedral St.

JUL 12 1929 19 Filed C. HAMPSON JONES, M. D. Per C.F.H. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12-1929

17 I HEREBY CERTIFY, That I attended deceased from Since 10 yrs ago to July 11, 19 29

that I last saw him alive on " 11, 19 29

and that death occurred, on the date stated above, at 5-0 a. m.

The CAUSE OF DEATH* was as follows:

Exhaustion

(duration) yrs. mos. 4 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis + Prostatism

Heart Prostration (duration) 4- yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? c

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Evidence

(Signed) Barrett H Catlin, M. D.

, 19 (Address) 1404 Linden Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn Cemetery — DATE OF BURIAL July 13 1929

20 UNDERTAKER George W. Zickler — ADDRESS 1737 E. Eager St.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47599

CERTIFICATE OF DEATH

74-801 E 47599

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1827 E. Lafayette Ave 8-17 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Nicholas S. Harp.

(a) RESIDENCE NO. 1827 E. Lafayette Ave. WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widower

6a If married, widowed, or divorced BUSBAND of (or) WIFE of Elizabeth A. Harp.

6 DATE OF BIRTH (month, day, and year) Feb 8-1858

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	71	5	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Marine Engineer ret'd

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto, Md.

PARENTS

10 NAME OF FATHER Edw. Harp.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto, Md.

12 MAIDEN NAME OF MOTHER Mary E. Staak

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto, Md.

14 Informant Edward L. Harp

(Address) 1827 E. Lafayette Ave

15 Filed 1-7 1929 16 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11-1929

17 I HEREBY CERTIFY, That I attended deceased from 6-24-, 1929, to 7-11-, 1929

that I last saw h[illegible] alive on July 10, 1929

and that death occurred, on the date stated above, at 1.40 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death? ~

Did an operation precede death? No Date of ~

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Geo Heller M. D.

[illegible] 1929 (Address) 1937 Gough St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oaklawn Cemetery

DATE OF BURIAL July 15 1929

UNDERTAKER George W Jenkins

ADDRESS 1737 E. Eager st

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Rks.

E 47600 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH. 32 E 47600

1-PLACE OF DEATH JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. 96-32 ST. WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Violet Carnohan

(a) RESIDENCE NO. 502 S- Newkirk St

(Usual place of abode) ST. WARD

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 9/16/27

7 AGE — Years: 1 — Months: 9 ~~27~~ — Days: 26 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Frank Carnohan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Nettie Phelps

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant (Address) Johns Hopkins Hospital Records

15 Filed JUL 12 1929 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 1929

17 I HEREBY CERTIFY, That I attended deceased from June 29, 1929, to July 12, 1929, that I last saw her alive on July 12, 1929, and that death occurred, on the date stated above, at 12.30 A m.

The CAUSE OF DEATH* was as follows:

Tuberculosis of meninges
(Tuberculous Meningitis)

(duration) yrs. 1 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes.

What test confirmed diagnosis?

(Signed) S. C. Goodwin M. D.

7/12 1929 (Address) J. H. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel Cemetery — DATE OF BURIAL: July 15 1929

20 UNDERTAKER: George N. Zinkler — ADDRESS: 737 E. Eager St

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47601 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47601

CERTIFICATE OF DEATH

129

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1835 N Spring ST., 9-18 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary E. Climm

(a) RESIDENCE NO. 1835 N Spring ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Widowed

a If married, widowed, or divorced, HUSBAND of (or) WIFE of Walter Climm

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	about 57	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer at Home

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER Clem W. Johnson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER Angeline Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Co.

14 Informant Grace W. Miles (daughter)

(Address) 20 E 112th st New York City

15 Filed JUL 13 1929, 19 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10, 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb, 1929, to July 10, 1929, that I last saw h alive on July 9, 1929, and that death occurred, on the date stated above, at 10 P.M.

The CAUSE OF DEATH* was as follows:

Chronic Interstial Nephritis

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis, Hypertension

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R. Upshur, M. D.

7/12, 1929 (Address) 1129 E Monument st

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Asbury Evergreen Cemetery	7/14/ 1929
20 UNDERTAKER	ADDRESS
Mrs Chas G. Bailey	1421 Jefferson St

L 13 1929

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47602

CERTIFICATE OF DEATH

E 47602

REGISTERED NO. 182

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) 2902 Reisterstown Rd. (St.) 15-54 Ward

2-FULL NAME Richard S. Cooper.

(a) RESIDENCE: (No.) 2902 Reisterstown Rd. (St.) Ward

(Usual place of abode)

Length of residence in city or town where death occurred 21 yrs. 10 mos. 8 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of no.

6 DATE OF BIRTH (month, day, and year) Aug 28-1907

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	21	10	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Clerk.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER Simon Cooper

11 BIRTHPLACE OF FATHER (city or town) Russia
(State or country)

12 MAIDEN NAME OF MOTHER Ida Steinman

13 BIRTHPLACE OF MOTHER (city or town) Russia
(State or country)

14 Informant Jerome Leonard
(Address) 2601 Liberty Heights

15 Filed ..... 19 C. HAMPSON JONES, M.D. Registrar

L 13 1929 Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Accident.
Drowned.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Heart attack, fell in bath tub of fresh water

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? home

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) July 12th 1929 Regular Hoffman M. D.
(Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Friendship Cem

DATE OF BURIAL July 13 1929

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E. Baltimore St

NOTICE TO PHYSICIANS—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 47603 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47603

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 5705 (Maple Ave ST.) 21-55 (WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Henry C. Gartside

(a) RESIDENCE NO. 5705 (Maple Ave ST.) WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred life mos ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Emma J. Gartside

6 DATE OF BIRTH (month, day, and year)

7 AGE — Years: 92 ? — Months — Days — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Iron Moulder
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer 047

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Henry C. Gartside

11 BIRTHPLACE OF FATHER (city or town) (State or country): England

12 MAIDEN NAME OF MOTHER: Cordelia Hayes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): U. S. A.

14 Informant: Silas L. Gartside
(Address) 2747 N. North Ave

15 Filed ..... 19.. C. HAMPSON JONES, M. D. Registrar
Per .....

L 13 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-12 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct. 1928 to July 12 1929,
that I last saw him alive on July 11 1929
and that death occurred, on the date stated above, at 2 A. m.
The CAUSE OF DEATH* was as follows:

Paralysis 2d
(Cerebral Hemorrhage)
(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Senility
(duration) 10 yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical & Clinical Exam

(Signed) C. B. Turner M. D.
7-12-1929 (Address) 4936 Park Heights Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Druid Ridge — DATE OF BURIAL 7-15 1929

20 UNDERTAKER: D. J. Ruck — ADDRESS 6403 Belair Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Blks.

E 147665 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓

CERTIFICATE OF DEATH. X 49 E 47604

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 9-4 WARD)

2-FULL NAME Dr Leonidas Daniel

(a) RESIDENCE NO. Cocoa Fla. ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary

6 DATE OF BIRTH (month, day, and year) 4/3/63

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	65	10	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Dentist. ~~Physician~~

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ga

PARENTS

10 NAME OF FATHER Abram Daniel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ga

12 MAIDEN NAME OF MOTHER Sarah Shipsheer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ga

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed , 19 C. HAMPSON JONES, M. D. Registrar

L 13 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 1929

17 I HEREBY CERTIFY, That I attended deceased from May 1 , 1929 , to July 13 , 1929.

that I last saw him alive on July 13 , 1929,

and that death occurred, on the date stated above, at 5.55 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Bladder (Urinary).

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Bronchial Pneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Cocoa Fla.

Did an operation precede death? yes. Date of May 10, 1929

Was there an autopsy?

What test confirmed diagnosis?

(Signed) E. E. James, M. D.

, 19 (Address) Johns Hopkins Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cocoa Florida — DATE OF BURIAL 22 May

20 UNDERTAKER Joseph Abrams — ADDRESS 7/13/29

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 47605 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47605

CERTIFICATE OF DEATH.

1-PLACE OF DEATH St. Agnes. Hospital

CITY OF BALTIMORE: (No. Kelbourne Ave. Balto. St. 70-64 1-001 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Anna Noll.

(a) RESIDENCE NO. 2422 Lauretta Ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if of foreign birth? 8 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced ~~Husband of~~ or) WIFE of: the late Jos. Noll

6 DATE OF BIRTH (month, day, and year): Nov 20/71

7 AGE: Years 57 Months 7 Days 22 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Hungary.

PARENTS

10 NAME OF FATHER: Jos. Strabel

11 BIRTHPLACE OF FATHER (city or town) (State or country): Hungary

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Hungary

14 Informant: Mrs. Ann Kohn (Address) 2422 Lauretta Ave

15 Filed JUL 13 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7-12 1929

17

I HEREBY CERTIFY, That I attended deceased from 7-1, 1929, to 7-12, 1929,

that I last saw h alive on 7-12, 1929

and that death occurred, on the date stated above, at 1 00 A m.

The CAUSE OF DEATH* was as follows:

Typhoid fever

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Nicholas N. Bonello, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: 7/15 1929

20 UNDERTAKER: Philip Herrig — ADDRESS 3016 Orleans

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47606 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

125 E 47606

1—PLACE OF DEATH REGISTERED NO.

CITY OF BALTIMORE: (No. University Hospital ST. 70-78 WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna L. H. Wille

(a) RESIDENCE NO. 2933 [redacted] ST. W. Mosher WARD 16th
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 63 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry L. Wille

6 DATE OF BIRTH (month, day and year) Oct 31. 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	63	8	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER John N. Gruninger

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Hermina Helsemann

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Henry L. Wille
(Address) 2933 N. Mosher St

15 Filed July 17 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 11, 1929, to July 16, 1929, that I last saw her alive on July 16, 1929 and that death occurred, on the date stated above, at 7 50 A.m.

The CAUSE OF DEATH* was as follows:

Acute hemorrhagic pancreatitis
Cholecystitis

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? yes Date of July 14 1929

Was there an autopsy?

What test confirmed diagnosis? Operation

(Signed) Lewis P. Tuneys, M. D.

July 18 1929 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	July 15 1929

20 UNDERTAKER Mr. & Mrs. John W. Teufel & Son ADDRESS 801 W. Fayette

IMPORTANT. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47607

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 47607

CERTIFICATE OF DEATH

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO. 1627

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Peter W. Delss

(a) RESIDENCE NO. 522 17th ? ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if foreign birth? — yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	?

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Lab None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) ? Md

PARENTS

10 NAME OF FATHER Christian Delss

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Md.

12 MAIDEN NAME OF MOTHER Carrie Miller

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Germany

14 Informant Records of (Address) BALTIMORE CITY HOSPITALS

15 Filed 7-13-1929, 19 E. HAMPSON JONES, M. D. Registrar

ACH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-11-29

17

I HEREBY CERTIFY, That I attended deceased from 7-2, 19 29, to 7-11, 19 29, that I last saw h alive on 7-, 19 29, and that death occurred, on the date stated above, at 10 75 4 m.

The CAUSE OF DEATH* was as follows:

Myocarditis, chronic & acute

Myocardial Insufficiency

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Phys. Exam. Lab. Autopsy

(Signed) Hamon W. McLaughlin, M. D.

7-11, 1929 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount DATE OF BURIAL 7/13 19 29

20 UNDERTAKER Wm Cook ADDRESS 1217 E Pratt

OF DEATH in plain terms, so that it may be properly classified. Each statement of OCCUPATION must be important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47608

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 47608

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE (No.) 6376 North Ave (STREET OR AVENUE) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME E. Catherine Daughaday

(a) RESIDENCE NO. 6376 North ST. 20 WARD

(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: W.

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6 DATE OF BIRTH (month, day and year): Aug 27 1848

7 AGE — Years: 80 — Months: 10 — Days: — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Shippensburg Pa

PARENTS

10 NAME OF FATHER: Wm A Kipphey

11 BIRTHPLACE OF FATHER (City or town) (State or country): Pa

12 MAIDEN NAME OF MOTHER: Catherine Duncan

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Pa

14 Informant: Miss Alice Buck

(Address) 6376 North ave

15 Filed ..... 19 ..... Registrar

L 13 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year): July 11 1929

17 I HEREBY CERTIFY, That I attended deceased from July 8 19 29 to July 11 19 29

that I last saw her alive on July 11 19 29

and that death occurred, on the date stated above, at 1130 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

CONTRIBUTORY (Secondary) Pneumonia (duration) 2 yrs. mos. ds. (Hypo-Static)

18 Where was disease contracted if not at place of death? (duration) yrs. mos. ds.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) George E Shannon M. D.

July 12 29 (Address) 700 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park Cem DATE OF BURIAL: July 13 19 29

20 UNDERTAKER: John O Mitchell ADDRESS: Sons 1900 Eutaw Place

DEATH in plain terms, so that it may be properly classified. Fact important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 47609

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

87-E 47609

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH Pronounced dead at the

City of Baltimore: (No. Mercy Hospital. St. 22-20 Ward)

2-FULL NAME Matthew F.Gerve.

(a) RESIDENCE NO. 530 S.Paca St. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 8 yrs. ---- mos. ---- ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White.	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) February 19.1909

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	20	4	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Shipping clerk.
(b) General nature of industry, business, or establishment in which employed (or employer) Central Overall Co.
(c) Name of employer

9 BIRTHPLACE (city or town) Reading Pa.
(State or country)

PARENTS

10 NAME OF FATHER Simon Gerve.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Lithuania.

12 MAIDEN NAME OF MOTHER Elizabeth Braugatis.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Lithuania.

14 Informant Simon. Gerve. (father)
(Address) 530 S.Paca St.

15 Filed ... 19 ... C. HAMILTON JONES, M. D. Registrar

13 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:
Fracture of the skull.
Accidental fall down elevator shaft.

(duration) ... yrs. ... mos. ... ds.
CONTRIBUTORY (Secondary)
(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? 112 Hanover St. 7/11/29
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? Inquiry
(Signed) Otto H. Leinhardt, M. D.
7/12, 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	July 15. 1929
20 UNDERTAKER	ADDRESS
John Grebliauckas	423 S.Paca.St.

F.S.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47610

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

47 E 47610

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1619 Montepelier ST., 9-46 WARD)

2—FULL NAME Margaret C. Tucker

(a) RESIDENCE NO. 1617 Montepelier St ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Benjamin L. Tucker

6 DATE OF BIRTH (month, day, and year) Mar 7 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	75	4	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) A. A. Co. Md.

PARENTS

10 NAME OF FATHER Gasway Owens

11 BIRTHPLACE OF FATHER (city or town) A. A. Co. Md. (State or country)

12 MAIDEN NAME OF MOTHER Marceline Drury

13 BIRTHPLACE OF MOTHER (city or town) A. A. CO. (State or country)

14 Informant Mr. Francis Tucker

(Address) 1617 Montepelier St

15 Filed ..... 19 ..... HAMSON JONES, M. D. Registrar

L 13 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 1929

17 I HEREBY CERTIFY, That I attended deceased from April 12, 1929, to July 12, 1929

that I last saw her alive on July 11, 1929

and that death occurred, on the date stated above, at 4:30A m.

The CAUSE OF DEATH* was as follows:

Carcinomatosis — Original focus L. breast,

(duration) 1 yrs mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of 1925?

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Fritz J. Kinzey, M. D.

7/13, 1929 (Address) 2700 Harford Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Owensville Episcopal Cem.	July 15 1929
20 UNDERTAKER	ADDRESS
J. Fenn McCully	100 E. Fort

OF DEATH in plain terms, so that it may be properly classified. Exact statement of occupation is important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47611

CERTIFICATE OF DEATH

E 476[illegible]

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 3000 Edmondson Ave ST. 16-70 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rev. Thomas J. Kervick

(a) RESIDENCE NO. 3000 Edmondson Ave ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. [illegible] mos. [illegible] ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 28, 1857.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	72	5	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Priest Catholic

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Keiran J. Kervick

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary C. King

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ohio

14 Informant: Cecil Kervick
(Address): 3000 Edmondson Ave.

15 Filed [illegible], 19[illegible] HAMILTON JONES, M. D.
By [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11th 29.

17 I HEREBY CERTIFY, That I attended deceased from June 28, 1929, to July 11, 1929.

That I last saw him alive on July 11, 1929

and that death occurred, on the date stated above, at 2-30 P m.

The CAUSE OF DEATH* was as follows:

Thrombo Angeitis Obliterans

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Chronic Arterial Hypertension

(duration) 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Exam

(Signed) L. C. Lally, M. D.

, 19 (Address) 3577 Edmondson

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — DATE OF BURIAL: 7-15-29

20 UNDERTAKER: Martin Fahey & Sons — ADDRESS: 1827 N. Monroe Ave.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47612

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

× 10-002

E 47612

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sydenham Hospital (STREET) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Doris Marie Whitmore

(a) RESIDENCE NO. Woodlawn, Md (STREET) WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 0 yrs. 0 mos. 1 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Sept. 28, 1915

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	13	9	14	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer) School

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) New Jersey

PARENTS

10 NAME OF FATHER Arthur Whitmore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Charlestown W. Va.

12 MAIDEN NAME OF MOTHER Emma Hunter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New Jersey

14 Informant Arthur Whitmore

(Address) Woodlawn, Md

Filed JUL 13 1929, 19 —

Registrar —

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1929, to July 12, 1929, that I last saw her alive on July 12, 1929 and that death occurred, on the date stated above, at 6:20 p.m.

The CAUSE OF DEATH* was as follows:

Pharyngeal Diphtheria

(duration) 0 yrs. 0 mos. 5 ds.

CONTRIBUTORY (Secondary) Acute Diphtheritic Myocarditis (duration) 0 yrs. 0 mos. 1 ds.

18 Where was disease contracted if not at place of death? Woodlawn, Md

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical findings

(Signed) Addison Craft Irby, M. D.

7-12 1929 (Address) Sydenham Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cemetery — DATE OF BURIAL: 7/13 1929

20 UNDERTAKER: Wm Cook — ADDRESS: 1217 St Paul

IMPORTANT. See instructions on back of certificates. Each statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—MAT—1500 Bks.

226589

E 47613

1-PLACE OF DEATH

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 47613

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. 19-9 WARD)

2-FULL NAME Barnett Opell

(a) RESIDENCE No. 750 Howard Ave ST., WARD Brooklyn N.Y.
(Usual place of abode)
Length of residence in city or town where death occurred [redacted] yrs. mos. 14 ds. How long in U. S., if of foreign birth? 70 yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Esther Opell

6 DATE OF BIRTH (month, day, and year) unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	58			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work metal worker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer unknown

9 BIRTHPLACE (city or town) (State or country) N. Y.

PARENTS

10 NAME OF FATHER Morris Opell

11 BIRTHPLACE OF FATHER (city or town) unknown (State or country) Russia

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed JUL 13 1929 19 G. HAMILTON JONES, M. D. Registrar

By [redacted]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 19 29

17 I HEREBY CERTIFY, That I attended deceased from June 24, 19 29 to July 13, 19 29, that I last saw h[redacted] alive on July 13, 19 29, and that death occurred, on the date stated above, at 12 m.

The CAUSE OF DEATH* was as follows:

Brain Tumor - Biopsy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 5 July 29

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) E. H. Campbell M. D.

19 (Address) John Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New York City DATE OF BURIAL July 13 19 29

UNDERTAKER [redacted] ADDRESS [redacted] St. Louis Mo.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-lv-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47614

CERTIFICATE OF DEATH.

31 E 47614

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Sinai Hosp ST., 15-66 WARD)

2-FULL NAME Mrs Rose Friedman

(a) RESIDENCE NO. 1622 Ruxton ave (Usual place of abode) Sinai Hospital ST., WARD

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	married

5a If married, widowed, or divorced HUSBAND of or) WIFE of Benjamin

6 DATE OF BIRTH (month, day, and year) 1881

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	48 yrs	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Harry Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Bessie —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Ben. Friedman (Address) 1622 Ruxton ave

15 Filed JUL 14 1929 C. HAMPSON JONES, M. D. Registrar

Per RPG

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 1929

17 I HEREBY CERTIFY, That I attended deceased from June 8 1929, to July 12 1929, that I last saw h[illegible] alive on July 12 1929, and that death occurred, on the date stated above, at 6.50 a.m.

The CAUSE OF DEATH* was as follows:

Acute Cardiac Dilatation

Chronic Hypertension C.V. Disease

Cysts Nephrosis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Nephrectomy

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of June 24 1929

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) S. J. Kaplan M. D.

7/12/1929 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL Hebrew Rosedale — DATE OF BURIAL 7/14 1929

20 UNDERTAKER Sol Levinson & Bro ADDRESS 1127 E Baltimore st

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47615

E 47615

49

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital ST.) 5-6K (WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benj. Rabinowitz.

(a) RESIDENCE NO. 1705 Moreland ST., ... WARD ...

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? 28 yrs. mos. ds.

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPA- TION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jennie Rabinowitz

6 DATE OF BIRTH (month, day, and year) 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	58	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer) Self

(c) Name of employer Russia

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER Morris Rabinowitz

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant (Address) Jennie Rabinowitz 1705 Moreland Ave

15 Filed JUL 14 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/14 1929

17

I HEREBY CERTIFY, That I attended deceased from 7/10 . 1929 , to 7/14 . 1929 .

that I last saw him alive on 7/14 . 1929 ,

and that death occurred, on the date stated above, at 5 P. m.

The CAUSE OF DEATH* was as follows:

Tumor Malignancy of the kidney.

(duration) 4 yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia.

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Xray.

(Signed) J. E. Goodman , M. D.

July 14 1929 (Address) Sinai Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Southern ave

DATE OF BURIAL July 14 1929

20 UNDERTAKER S. Levinson Bro

ADDRESS 1127 E Balto St

Spec.—1-10-21—M&T—1500 Bks.

E 47616 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47616

CERTIFICATE OF DEATH.

1-PLACE OF DEATH Sinai Hospital. 57

CITY OF BALTIMORE: (No. ST. 5-8 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Dora Nickelson

(a) RESIDENCE No. 832 E. Baltimore ST., WARD

(Usual place of abode) (If non-residents give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? 38 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed.

5a If married, widowed, or divorced HUSBAND (or) WIFE of Harry Nickelson

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or ... min.
65	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework.

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unread

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant adolph Nickelson

(Address) 832 E. Balto

15 Filed JUL 14 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14 1929

17 I HEREBY CERTIFY, That I attended deceased from July 2 , 1929 , to July 14 , 1929 , that I last saw her alive on July 14 , 1929 , and that death occurred, on the date stated above, at 4.50 a.m.

The CAUSE OF DEATH* was as follows:

Diabetes —

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia (Lobar)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown.

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) J. K. Goodman M. D.

, 19 (Address) Sinai Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Herman Run DATE OF BURIAL July 14 1929

20 UNDERTAKER Jack Levis 1439 ADDRESS Eutaw

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47617

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

46

E 47617
REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE; (No. 5101 Queensberg Ave ST. 13-54 WARD)

2—FULL NAME Frida Huldberg

(a) RESIDENCE NO. 2219 Callow Ave ST.. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 21 yrs. mos. ds. How long in U. S., if foreign birth? 21 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Joseph Huldberg

6 DATE OF BIRTH (month, day, and year): Sept 30 1877

7 AGE: Years 51 52 | Months 9 | Days 13 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Hirsh Helen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Sarah Bressler

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Harry Goldberg

(Address) 2219 Callow Ave

15 Filed 1929 CHARLES JONES, M. D. Registrar. By R.P.K.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7-13-29

17 I HEREBY CERTIFY, That I attended deceased from June 1- 1929 to July 13-29 1929, that I last saw h- alive on July 10 6.25 1929, and that death occurred, on the date stated above, at 4.20 P.M.

The CAUSE OF DEATH* was as follows:

Malignant tis. - Abdominal Organs

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary): General Exhaustion

(duration) yrs. 1 mos. — ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Yes Date of May 25/29

Was there an autopsy? No

What test confirmed diagnosis? Exploratory Incision

(Signed) Frank C Bressler M. D.

7/14, 1929 (Address) 125 St Paul

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mehrer Benedict | DATE OF BURIAL: 7/14 1929

20 UNDERTAKER: Jack Lewis 1439 E Baltimore St | ADDRESS

If DEATH in plain terms, so that it may be properly classified. EXACT statement of OCCUPATION is important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47618 — CERTIFICATE OF DEATH. — 102 — E 47618

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2616 Sadyet ST. 25-12 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William A. Hall

(a) RESIDENCE No. 2616 Sadyet ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mary J. Hall

6 DATE OF BIRTH (month, day, and year): Feb 22 1875

7 AGE — Years: 54 — Months: 4 — Days: 18 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clothes Sponger 056

(b) General nature of industry, business, or establishment in which employed (or employer): Slatts Bro.

(c) Name of employer: Butt pace. Va.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER: Otway Hall

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Jane Brockett

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Mary J. Hall (Address) 2616 Sadyet St

15 Filed JUL 14 1929 — CATHERINE JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 11 1929

17 I HEREBY CERTIFY, That I attended deceased from June 9, 1929, to July 11, 1929, that I last saw h alive on July 10, 1929, and that death occurred, on the date stated above, at 3 a m.

The CAUSE OF DEATH* was as follows:

Bronchial asthma

(duration) 3 yrs. mos ds.

CONTRIBUTORY (Secondary) Emphysema

(duration) no yrs. no mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symptoms

(Signed) Raymond V. Heaven, M. D.

July 11, 1929 (Address) Lakewood

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Zion Cem. — DATE OF BURIAL: July 14 1929

20 UNDERTAKER: Samuel Kemeley — ADDRESS: 5 W Biddle

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47619

CERTIFICATE OF DEATH.

75-001

E 47619
REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 214 S. Ann ST. 2-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Benj. Sobus

(a) RESIDENCE NO. 214 S. Ann ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	W	

5a If married, widowed, or divorced HUSBAND of or) WIFE of —

6 DATE OF BIRTH (month, day, and year) April 8-1928

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	1	3	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Leon Sobus.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland.

12 MAIDEN NAME OF MOTHER Cecilia Buchwich

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland.

14 Informant Leon Sobus
(Address) 214 S. Ann St.

15 Filed JUL 19 1929 C. HAMILTON JONES, M. D. Registrar

UL 14 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14 1929

17 I HEREBY CERTIFY, That I attended deceased from July 13, 1929, to July 14, 1929, that I last saw h[illegible] alive on July 14, 1929, and that death occurred, on the date stated above, at 5 a. m.

The CAUSE OF DEATH* was as follows:

Acute Cerebral Paralysis (hemoplegia)

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary) hemiplegia

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? at residence

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) David A. Strayhorn M. D.

7/14, 1929 (Address) 109 E. Preston

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St. Stanislaus Cem. DATE OF BURIAL July 16 1929

20 UNDERTAKER George A. Weber ADDRESS 705 S. Ann St.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47620

CERTIFICATE OF DEATH.

129

E 47620

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 1427 John St. 14-20 Ward)

2-FULL NAME John A. Coates

(a) RESIDENCE NO. 1427 John St St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: ~~Male~~

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): May 18—1864

7 AGE — Years: 65 | Months: 1 | Days: 25 | IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Baggage Master

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer B & O. R.R. 013

9 BIRTHPLACE (city or town): Balto. Md

(State or country)

PARENTS

10 NAME OF FATHER James A. Coates

11 BIRTHPLACE OF FATHER (city or town):

(State or country) Kentucky

12 MAIDEN NAME OF MOTHER Lettra Campbell

13 BIRTHPLACE OF MOTHER (city or town):

(State or country) New York

14 Informant Mrs. Harper

(Address) 1427 John St.

Filed JUL 14 1929, H. LAWSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13th 1929

17 I HEREBY CERTIFY, That I attended deceased from 1910, 19..., to July 13th, 1929, that I last saw him alive on July 12th, 1929, and that death occurred, on the date stated above, at 9.40 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

at least (duration) 10 yrs. mos. ds.

CONTRIBUTORY Heredity

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) J. D. Gibbert, M. D.

7-13-1929 (Address) 211 W. Lanvale

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery — Date of Burial 7/16 1929

20 UNDERTAKER: Chas. R. Ward & Son — ADDRESS 118 W. Mt. Royal Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JUL 14 1929

Spec.—2-29-28—L. F. S.—500 Bks.

E 47621

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

65-001

E 47621

1—PLACE OF DEATH Union Memorial Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. 33rd + Calvert Sts ST. 1244 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elmer C. Wachter

(a) RESIDENCE NO. 204 N. Market ST., WARD Frederick, Md.
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 20 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or WIFE of) Mrs. Elmer C. Wachter

6 DATE OF BIRTH (month, day, and year) March 11, 1880

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	49	4	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired hotel Manager

(b) General nature of industry, business, or establishment in which employed (or employer) Hotel management

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Charles C. Wachter

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Ida Michael

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Self

(Address)

15 Filed JUL 14 1929, 19 HAMILTON JONES, M. D. Registrar

By Ray

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 23, 1929, to July 13, 1929, that I last saw him alive on July 13, 1929 and that death occurred, on the date stated above, at 1:10 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Lymphatic Leukemia

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Frederick Md.

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? autopsy findings blood examination

(Signed) Francis N. Gluck, M. D.

7/13, 1929 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet New Frederick Md

DATE OF BURIAL July 15 1929

20 UNDERTAKER Joseph B Cook

ADDRESS 1013 N Eutaw St

IMPORTANT. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47622

CERTIFICATE OF DEATH

E 47622

1—PLACE OF DEATH

REGISTERED NO. 21-24 29

CITY OF BALTIMORE: (No. 1130 Sargeant St. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Jacob Mueller

(a) RESIDENCE NO. 1130 Sargeant ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary E. Mueller

6 DATE OF BIRTH (month, day, and year) May 19, 1852

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	77	1	23	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Mr. Mueller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Mr. George R. Mueller

(Address) 3903 Dalrymple Ave.

15 Filed JUL 14 1929 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12, 1929

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1928, to July 12, 1929, that I last saw h. 1m. alive on July 11, 1929, and that death occurred, on the date stated above, at 3 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Myocardial Insufficiency

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic Interstitial Nephritis

(duration) Indefinite yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Autopsy

(Signed) Eugene C. Pierce, M. D.

7/13, 1929 (Address) 1500 Hollins St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL July 15, 1929

20 UNDERTAKER Joseph B. Cook

ADDRESS 1003 West Baltimore St

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47623

HEALTH DEPARTMENT—CITY OF BALTIMORE

24-001 E 47623

CERTIFICATE OF ~~DEATH~~ Light Negro.

REGISTERED NO. 25-13

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2314 Ampere St. (ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Carrie Penbroke Tyler.

(a) RESIDENCE NO. 2314 Ampere St. WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John Tyler

6 DATE OF BIRTH (month, day, and year) June 18 1902

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	27	—	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House wife

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Ephraim Penbroke

11 BIRTHPLACE OF FATHER (city or town) Baltimore Md.
(State or country)

12 MAIDEN NAME OF MOTHER Carrie Chase

13 BIRTHPLACE OF MOTHER (city or town) Baltimore Md.
(State or country)

14 Informant Carrie Penbroke Tyler
(Address) 2314 Ampere St.

15 Filed July 17, 1929 C. HAMPSON JONES, M. D. Registrar

L 14 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/13/29

17 I HEREBY CERTIFY, That I attended deceased from 7/6, 1929, to 7/13, 1929 that I last saw h alive on 7/12/29, and that death occurred, on the date stated above, at 1.04 p.m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Gastro Ulcer

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Stafford Dorsey, M. D.

, 19 (Address) 727 Cathedral

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION, OR REMOVAL	DATE OF BURIAL
Mt Auburn	July 16-29

20 UNDERTAKER Edward L Fink ADDRESS 739 Lexington St.

IF DEATH in plain terms, so that it may be properly classified. Each statement of fact is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 47624 129 E 47624

E. 47624

1-PLACE OF DEATH

REGISTERED No. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 1218 E Preston ST. 9-18 WARD)

2-FULL NAME Elizabeth Brownley

(a) RESIDENCE No. 1218 E Preston ST., ... WARD .....
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 71 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Otis C. Brownley Sr.

6 DATE OF BIRTH (month, day, and year): Feb. 4-1858

7 AGE: 71 Years | Months: 5 | Days: 8 | If LESS than 1 day, ... hrs. or ... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Home Wife

(b) General nature of indnstry, business, or establishment in which employed (or employer)

(c) Name of employer

037

9 BIRTHPLACE (city or town) (State or country): Md Baltimore

PARENTS

10 NAME OF FATHER: David Foster

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Elizabeth Ford

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balti

14 Informant: Otis C Brownley Sr.
(Address): 1218 E Preston St.

15 Date: JUL 14 1929 Registrar: HARRISON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 12 1929

17 I HEREBY CERTIFY, That I attended deceased from June 1 1929, to July 12 1929, that I last saw h alive on July 14 1929 and that death occurred, on the date stated above, at 4 15 P m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Endocarditis

(duration) yrs 3 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) John T Avery M. D.

(Address) 1603 E Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn Cem. DATE OF BURIAL: July 15 1929

20 UNDERTAKER: Wm C. Black ADDRESS: 927 N Broadway

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47625

CERTIFICATE OF DEATH

X 11-002

REGISTERED NO. E 47625

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 4 22 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Henry Bauhause

(a) RESIDENCE NO. Willow Ave Towsdown WARD 13th District
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Christena J.

6 DATE OF BIRTH (month, day, and year): May 8-1893

7 AGE: Years 36 | Months 2 | Days 3 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Glass worker

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: Columbia Glass Co.

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Louis Bauhaus

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Jeanette Seymour

13 BIRTHPLACE OF MOTHER (city or town) (State or country): St Marys Co. Md.

14 Informant: Christina A Bauhaus

(Address): Willow Ave Towsdown Md

15 Filed 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 11, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 2, 1929, to July 11, 1929, that I last saw him alive on July 11, 1929 and that death occurred, on the date stated above, at 11.25 A m.

The CAUSE OF DEATH* was as follows:

Perforated duodenal ulcer

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) Broncho pneumonia and Heart failure (duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 2, 1929

Was there an autopsy? Yes

What test confirmed diagnosis? Operation - Clinical - Autopsy

(Signed) Luther C. Leitz, M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park

DATE OF BURIAL: 7/15, 1929.

20 UNDERTAKER: Fredk R Cole

ADDRESS: 1617 Broadway

IF DEATH is plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47626

CERTIFICATE OF DEATH

E 47626

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 3039 W. Lanvale St. ST. 16-67 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George T. Day

(a) RESIDENCE NO. 3039 W. Lanvale St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 24, 1926

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
2	11	18	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of indnstry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER George I. Day

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Bertha O'Neill

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant George I. Day

(Address) 3039 W. Lanvale St.

15 Filed JUL 14 1929 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 11, 1929 to July 12, 1929 that I last saw h[illegible] alive on July 12, 1929 and that death occurred, on the date stated above, at 30 m.

The CAUSE OF DEATH* was as follows:

Acute Lobar Pneumonia

(duration) [illegible] yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? [illegible]

(Signed) [illegible], M. D.

July 13, 1929 (Address) 545 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cemetery	July 15, 1929

20 UNDERTAKER [illegible] ADDRESS [illegible]

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47627 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E. 47627

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 1203 Ashburton ST., 16-68 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Johanna A Crawford

(a) RESIDENCE NO. 1203 Ashburton ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Crawford

6 DATE OF BIRTH (month, day, and year): Jan 23/1864

7 AGE: Years 65 | Months 5 | Days 20 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Markham

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Markham

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: John Crawford

(Address): 1203 Ashburton

Filed JUL 15 1929 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 13/29

17 I HEREBY CERTIFY, That I attended deceased from April 10, 1920, to July 13, 1929, that I last saw him alive on July 12, 1929 and that death occurred, on the date stated above, at 2.30 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Chronic Bronchitis Kidney Disease (duration) 9 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) A. C. Hurst M. D.

7/13, 1929 (Address) 701 Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Not Carried

DATE OF BURIAL: 7/16 1929

20 UNDERTAKER: M. Bell Cook

ADDRESS: 1217 E Baltimore St

Spec.—1-12-23—M&T—500 Bks.

E 47628 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47628

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. West Balt. Gen. Hospital ST. 20-27 WARD)

REGISTERED NO. 118

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Rose Hamm

(a) RESIDENCE NO. 2020 Penrose Ave ST. WARD 24

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Conrad Hamm

6 DATE OF BIRTH (month, day, and year) Feb 19 1839

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	90	4	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer At Home

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Mrs. C. Hamm

(Address) 2020 Penrose Ave

15 Filed JUL 5 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/13/1929

17 I HEREBY CERTIFY, That I attended deceased from 7/12, 1929, to 7/13, 1929, that I last saw h[illegible] alive on 7/13, 1929 and that death occurred, on the date stated above, at 6.30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic intestinal obstruction

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary)

Senility (duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 7/10/29

Was there an autopsy? ~~No~~ Yes - Partial

What test confirmed diagnosis? Clinical

(Signed) [illegible] M. D.

, 19 (Address) West Balto Gen. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL London Park

DATE OF BURIAL 7/16 1929

20 UNDERTAKER H. A. Cook

ADDRESS 1217 E. Pratt St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47629

CERTIFICATE OF DEATH

31

E 47629

1—PLACE OF DEATH

REGISTERED NO. B-54

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William P. Curry

(a) RESIDENCE NO. 2703 Evergreen Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE of~~ Mary Curry

6 DATE OF BIRTH (month, day, and year) Aug. 3, 1864

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
64 65		11	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Bricklayer

(b) General nature of industry, business, or establishment in which employed (or employer) Oil

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) Baltimore, Md (State or country)

PARENTS

10 NAME OF FATHER Chas. Curry

11 BIRTHPLACE OF FATHER (city or town) Balto, Md. (State or country)

12 MAIDEN NAME OF MOTHER Mary Smith

13 BIRTHPLACE OF MOTHER (city or town) Balto, Md (State or country)

14 Informant Mrs. Betty Naddox

(Address) 2703 Evergreen Ave

15 Filed JUL 15 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14, 1929

17 I HEREBY CERTIFY, That I attended deceased from Sept. 24, 1928, to July 14, 1929, that I last saw h[illegible] alive on July 14, 1929 and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Cardiac Failure

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

(duration) 7 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Henry C. Smith, M. D.

, 19 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet Cemetery

DATE OF BURIAL 7/16 1929

20 UNDERTAKER William Cook

ADDRESS 1217 St Paul

IMPORTANT. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47630 E 47630

CERTIFICATE OF DEATH.

129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 417-W-23 ST., 12-51 WARD

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Margaret Ellen McGee

(a) RESIDENCE NO. 417-W-23 ST., 12 WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 70 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fe.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Edwin B. McGee

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE: Years 65 yrs; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Dublin Ireland

PARENTS

10 NAME OF FATHER: Thomas Fallon

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Mary ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant (Address): Margaret Ellen McGee 417-W-23rd St.

Filed JUL 15 1929 C. HAMILTON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 11 1929

17 I HEREBY CERTIFY, That I attended deceased from June 3, 1929, to July 11, 1929, that I last saw her alive on July 11, 1929, and that death occurred, on the date stated above, at 10.15 P.M.

The CAUSE OF DEATH* was as follows: Cardiac insufficiency

(duration) yrs. mos 1 ds.

CONTRIBUTORY (Secondary): Chronic interstitial nephritis

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? yes

What test confirmed diagnosis? Urinalysis

(Signed) Roscoe Brook, M. D.

July 11, 1929 (Address) 1438 Maryland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cemetery

DATE OF BURIAL: 7/15 1929

UNDERTAKER: William Cook

ADDRESS: 1217 St Paul

mation should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47631

CERTIFICATE OF DEATH

+ 170

E 47631

1-PLACE OF DEATH

City of Baltimore: (No. Emergency) (Hospital) Ward 11 24

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Bruce E. Williams

(a) RESIDENCE NO. Hotel Altamont St., Ward 9th

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 31 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 1891

7 AGE: Years 37 | Months 10 | Days | IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Canvasser
(b) General nature of industry, business, or establishment in which employed (or employer) Painter
(c) Name of employer Economics

9 BIRTHPLACE (city or town) Jo day
(State or country) Va

PARENTS

10 NAME OF FATHER Wm M. Williams

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Mary Stockton

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va

14 Informant Chas. R. Williams
(Address) Roanoke Va

Filed JUL 15 1929 19 C. HAMPSON JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Bullet Wound ... hrs.
Chest
While Mentally Deranged
Ordering (duration) on Veranda yrs. mos. ds.

CONTRIBUTORY (Secondary) Self Inflicted (duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Hotel Altamont

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) James M Kenton M. D.

7/16/29 (Address) 700 E Clare St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Blacksburg Va — DATE OF BURIAL: July 14 1929

20 UNDERTAKER: Harry A. Witzke — ADDRESS: 1314 W. Lombard

tion should be carefully supplied. AGE should be stated EXACTLY.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47632

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001

E 47632

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 936 N. Gilmor ST., 16-23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Bradford Clayton, Jr.

(a) RESIDENCE NO. 936 Gilmor ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 27. 1928

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
	11	26 16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Bradford Clayton, Sr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Annie Hicks

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Mother

(Address) 936 Gilmor St.

15 Filed JUL 15 1929, C. HAMPSON JONES, M.

Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/13/29

17 I HEREBY CERTIFY, That I attended deceased from 7/12/29, to 7/13/29.

that I last saw him alive on 7/13/29.

and that death occurred, on the date stated above, at 9.45 P. m.

The CAUSE OF DEATH* was as follows:

Bronchio-Pneumonia

(Primary)

(duration) yrs. mos. 4 ds.

CONTRIBUTORY

(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) W. B. Howard, M. D.

(Address) 912 Gilmor St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL W. M. Auburn — DATE OF BURIAL July 15 1929

20 UNDERTAKER Saml. W. Chase & Son — ADDRESS 140 W. Fayette

IF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47633 HEALTH DEPARTMENT—CITY OF BALTIMORE

40 ✓ E 47633

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Balto. City Hosp. ST. 15-21 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Nathaniel Hodges Rhodes

(a) RESIDENCE NO. 1405 N. Bruce ST., WARD

(Usual place of abode) Sife

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	29			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Chas. Rhodes

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Record

(Address)

15 Filed JUL 15 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/13/29

17

I HEREBY CERTIFY, That I attended deceased from 7/12, 1929, to 7/13, 1929

that I last saw h[illegible] alive on 7/13, 1929

and that death occurred, on the date stated above, at 10 a. m.

The CAUSE OF DEATH* was as follows:

Urethral stricture (Tuberculous)

Urinary Retention

Uraemia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Myocarditis, toxemia

(duration) yrs. mos. ½ ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? yes Date of 7/13/29

Was there an autopsy? No

What test confirmed diagnosis? Clinical, operation

(Signed) Lila Lumpkin, M. D.

7/13, 1929 (Address) Balto. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	July 15 1929
20 UNDERTAKER Thomas E. Kelson	ADDRESS 1307 Preston St.

IMPORTANT. See instructions on back of certificates. Exact statement of OCCUPATION is very important. See instructions on back of certificates. OF DEATH in plain terms, so that it may be properly classified.

Cor.—12-9-25—A Co.—200 Bks.

E 47634

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47634

88

CERTIFICATE OF DEATH.

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. St. Joseph's Hospital St. E-17 Ward)

2-FULL NAME Ella B. Kling

(a) RESIDENCE NO. 1215 N. Bond St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 1 mos. 8 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 4, 1879

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	50	1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Clerk

(b) General nature of Industry, business, or establishment in which employed (or employer)

(c) Name of employer Jordan -Stabler

9 BIRTHPLACE (city or town)

(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER William Kling

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Susan Ewalt

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Baltimore, Md.

14 Informant Susan Kling

(Address) 1215 N.Bond St.

15 Filed ..... 19 ..... C. H. WILSON JONES, M. D.

JUL 24 1929

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry.) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Septic Endocarditis

(Autopsy at St. Joseph Hospital)

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) J. Allen Culler, M. D.

(Coroner)

7/13/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL — Date of Burial

Mount Olivet Cemetery July 15 1929

20 UNDERTAKER — ADDRESS

John F. Denny 715 Light St.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 47635

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47635

CERTIFICATE OF DEATH

1-PLACE OF DEATH Pronounced dead at the

City of Baltimore: (No. Mercy Hospital. St. 11-15 Ward)

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Horace Waters.

(a) RESIDENCE NO. 805 St Paul St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 72 yrs. 8 mos. 20 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	White	Single.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) March 22, 1856

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	72	8	20	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Pres. Building & Loan
(b) General nature of industry, business, or establishment in which employed (or employer) Association
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Cyrus Waters.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Emily Gambrill.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Maryland.

14 Informant Murray Tinges. (nephew.)
(Address) 3404 Oakfield Ave.

15 Filed JUL 15 1929 19 C. HAMPSON JONES, M. D. Registrar
By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Organic disease of the Heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted? If not at place of death? Gayette & Calvert Sts
Did an operation precede death? no. Date of July 12, 1929
Was there an autopsy? no.
What test confirmed diagnosis? Inquiry
(Signed) Chas Reinhardt, M. D.
7/13. 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Glen Mount Cem	July 15 1929
20 UNDERTAKER	ADDRESS
John O Mitchell & Son	Baltimore

U. S.—WRITE PLAINLY, with ink. Use no abbreviations. Do not leave any answer blank. If unknown, state 'unknown.' PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—12-9-25—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47636

CERTIFICATE OF DEATH.

E 47636

REGISTERED NO. 31

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 737 Augusta St. 10-14 Ward)

2-FULL NAME Joseph Shapiro

(a) RESIDENCE NO. 737 Augusta St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? 28 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced. (write the word): married

5a If married, widowed, or divorced (or) WIFE of: Tillie Shapiro

6 DATE OF BIRTH (month, day, and year): Ap 1874

7 AGE — Years: 55 — Months: — — Days: — — IF LESS than 1 day.....hrs. or.....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Grocer

(b) General nature of Industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town): Russia

(State or country)

PARENTS

10 NAME OF FATHER: Moses Shapiro

11 BIRTHPLACE OF FATHER (city or town): Russia

(State or country)

12 MAIDEN NAME OF MOTHER: Esther Harg

13 BIRTHPLACE OF MOTHER (city or town): Russia

(State or country)

14 Informant: Mrs. Shapiro

(Address) 737 Augusta St.

15 Filed JUL 15 1929, C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 14th 1929

17 I HEREBY CERTIFY, That I attended deceased from July 13 1929, to July 14th 1929 that I last saw h[illegible] alive on July 14th 1929 and that death occurred, on the date stated above, at 11:30 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary): Intestinal Tuberculosis

(duration) yrs. 6 mos. ds.

Is Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical Finding

(Signed) Alex A Weinstock, M. D.

7/15 1929 (Address) 733 Augusta St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale Date of Burial 7/15/29

20 UNDERTAKER: S. Levinson & Bro. ADDRESS 1127 Balto.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

Philip Finck

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47637

CERTIFICATE OF DEATH.

185

E 47637

1-PLACE OF DEATH

City of BALTIMORE: (No. Union Memorial Hospital St. 4th Ward)

REGISTERED NO._____

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Philip Finck

(a) RESIDENCE NO. 2805 Frisby St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Eleanor Finck

6 DATE OF BIRTH (month, day, and year) Feb 22nd 1856

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	73	7	29 21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

PARENTS

10 NAME OF FATHER Henry Finck

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Germany

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Eleanor Finck

(Address) 2805 Frisby st

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-20 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH was as follows:

Fracture of Skull

Due to a fall on street

Accidental

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) ..... yrs. ..... mos. ..... ds.

(Signed) ..... M. D.

(Coroner)

7/14. 1929 (Address) 5632 Roland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.....mos.....ds. In the State.....yrs.....mos.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem. Date of Burial July 16 1929

20 UNDERTAKER C. Hampton Moore M. D. ADDRESS Funeral Building 1126 Mount St

JUL 17 1929

Tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47638

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47638

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. 1-2 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles Kahlert

(a) RESIDENCE NO. 328 S. East Ave. ? ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred? ? yrs. ? mos. ? ds. ? How long in U. S., if foreign birth? — yrs. — mos. — ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of --

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) ?
(State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Kahlert

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) Maryland

12 MAIDEN NAME OF MOTHER Olive ?

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) Maryland

14 Informant Records of

(Address) Baltimore City Hospitals

Filed JUL 15 1929 HAMPSON JONES, M. D.
Registrar

By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 5, 1929, to July 13, 1929,

that I last saw him alive on July 13, 1929

and that death occurred, on the date stated above, at 5:45 A. m.

The CAUSE OF DEATH* was as follows:

Hemorrhage into Cerebrum

(duration) ... yrs. ? mos. ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Physical Exam. Autopsy

(Signed) Marvin M. McLean, M. D.

7-13, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St. Pauls Cemetery	July 16 1929
UNDERTAKER	ADDRESS
H. Sander Sons Inc.	1710 Eden St

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATIONS is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47639 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47639

CERTIFICATE OF DEATH

129

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO. 16-27

CITY OF BALTIMORE: (No. ..... ST., ... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mamie Martin (Bedford?)

(a) RESIDENCE NO. 724 N. Bruce ST., ... WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. ? How long in U. S., if foreign birth? ... yrs. ... mos. ... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	39			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laundress

(b) General nature of industry, business, or establishment in which employed (or employer): ?

(c) Name of employer: ?

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: Joseph Martin

11 BIRTHPLACE OF FATHER (city or town) (State or country): ? Maryland

12 MAIDEN NAME OF MOTHER: Sarah Jane Toppen

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ? Maryland

14 Informant: Records of
(Address): Baltimore City Hospitals

15 Filed JUL 15 1929, 19 ... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 12, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 24, 1929, to July 12, 1929.

that I last saw her alive on July 12, 1929

and that death occurred, on the date stated above, at 5:30 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic Interst. C
Nephritis

(duration) 1 yrs. ... mos. ... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis, Hypertension: Chronic Nephritis (duration) 1 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Phys. Exam. Laboratory

(Signed) Harris Gill McClain, M. D.

7-15, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	7-15-1929
20 UNDERTAKER: Daniel Easton	ADDRESS 946 Eutaw

IMPORTANT. See instructions on back of certificates. OF DEATH in plain terms, so that it may be properly classified.

UL 15 1929

Spec.—2-29-28—L. F. S.—500 Bks.

E 47640

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47640

CERTIFICATE OF DEATH

74-001

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1009 Brentwood Ave ST. 11-15 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Alderson

(a) RESIDENCE NO. 1009 Brentwood Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 46 yrs. — mos. — ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 30 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	75	—	13	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country) Harford Co. Md.

PARENTS

10 NAME OF FATHER Thomas Alderson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Mary J. Barton

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Pa.

14 Informant Miss Ella J. Alderson

(Address) 1009 Brentwood Ave

15 Filed JUL 15 1929 THAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 1929

17 I HEREBY CERTIFY, That I attended deceased from June 26 1929 to July 13 1929

that I last saw h alive on July 13 1929

and that death occurred, on the date stated above, at 7 40 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 17 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) H G Jones M. D.

7/14 1929 (Address) 720 N North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Olivet Cemetery	July 16 1929
20 UNDERTAKER	ADDRESS
Henry Hoen & Sons Inc.	130 E Eager

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47641

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47641

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO. 25-77

CITY OF BALTIMORE: (No. ST. WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William H. Wright

(a) RESIDENCE NO. 1509 Plum St., Curtis Bay ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred? yrs. ? mos. ? ds. ? How long in U. S., if foreign birth? ? yrs. ? mos. ? ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Separated

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: ~~laborer~~ Painter

(b) General nature of industry, business, or establishment in which employed (or employer): ? 050

(c) Name of employer: ?

9 BIRTHPLACE (city or town) (State or country): ? Unknown

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): ? Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ? Unknown

14

Informant: Records of

(Address) Balto. City Hospitals

Filed JUL 15 1929, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 12, 1929

17

I HEREBY CERTIFY That I attended deceased from July 8, 19 29 to July 12, 19 29

that I last saw h im alive on July 12, 19 29

and that death occurred, on the date stated above, at 1:10 P. m.

The CAUSE OF DEATH* was as follows:

Pellagra

Tuberculosis Lungs

(duration) 1? yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis Hemiplegia Left Side

(duration) ? yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Phys. Exam. Lab

(Signed) Warren E. McLean, M. D.

7-14, 19 29 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem.	July 15 19 29
20 UNDERTAKER: Chas. L. Brown	ADDRESS: 1201½ Fort Ave

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47642 HEALTH DEPARTMENT—CITY OF BALTIMORE 113 E 47642

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1306 S Highland ave ST. 26-1 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ruth J. Gardner

(a) RESIDENCE NO. 1306 Highland ave ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female | 4 COLOR OR RACE White | 5 Single, Married, Widowed, or Divorced, (write the word) Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day and year) Jan 23 1929

7 AGE Years | Months 5 | Days 22 | If LESS than 1 day, hrs. or min 4

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER George Gardner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto. md.

12 MAIDEN NAME OF MOTHER Stefanie Sobiesky

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto. md.

14 Informant Ruth Gardner

(Address) 1306 Highland ave

15 Filed JUL 15 1929 C. HAMPSON JONES Registrar Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) July 14, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 13 1929 to July 14, 1929

that I last saw her alive on July 14, 1929

and that death occurred on the date stated above at 6:30 p. m.

The CAUSE OF DEATH* was as follows:

Cholera Infantum

(duration) yrs mos. 4 ds.

CONTRIBUTORY (Secondary) Myocardial Insufficiency

(duration) yrs mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) I. B. Bromushas, M. D.

7-14 1929 (Address) 3037 O'Donnell St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemty | DATE OF BURIAL Sept 16 1929

20 UNDERTAKER George A. Weber | ADDRESS 706 S Conkling

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 47643 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47643

CERTIFICATE OF DEATH

31

1—PLACE OF DEATH

REGISTERED NO. 21-29

CITY OF BALTIMORE: (No. 1230 Carroll ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Charles T. J. Hunt

(a) RESIDENCE NO. 1230 Carroll ST. WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 12th 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	3	11		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stenographer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Timothy J. Hunt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Ella Fahey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mr Timothy J. Hunt

(Address) 1230 Carroll Ave

Filed JUL 15 1929 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12th 1929.

17 I HEREBY CERTIFY, That I attended deceased from July 6th 1929 to July 12 1929.

that I last saw h alive on July 12 1929

and that death occurred, on the date stated above, at 4.30 P. m.

The CAUSE OF DEATH* was as follows

Pulmonary Phthisis

(duration) 2 yrs. mos ds.

CONTRIBUTORY (Secondary) Anemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Case

(Signed) [illegible] M. D.

July 13 1929 (Address) 517 Lexington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL July 16 1929

20 UNDERTAKER John J. Cowan & Son

ADDRESS 901 Lexington

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47644

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47644

REGISTERED NO. 90

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 643 W. Fayette ST. 4-25 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Clark E. Doty

(a) RESIDENCE NO. 643 W. Fayette ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) ? 1870

7 AGE — Years: 59 — Months: — Days: — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Carpenter

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Bishing Creek Pa

PARENTS

10 NAME OF FATHER: Lawrence N Doty

11 BIRTHPLACE OF FATHER (city or town) (State or country): Bishing Creek Pennsylvania

12 MAIDEN NAME OF MOTHER: Clara Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Bishing Creek Pa

14 Informant: Mary Grasser

(Address) 643 W Fayette St

Filed JUL 15 1929 C. HAMPSON JONES, [illegible]

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14-29

17 I HEREBY CERTIFY, That I attended deceased from July 10 1929 to July 14th 1929, that I last saw him alive on July 14th 1929, and that death occurred, on the date stated above, at 12 noon m.

The CAUSE OF DEATH* was as follows:

Mitral Regurg

CONTRIBUTORY (Secondary) Cerebral Hemorrhage (duration) months yrs. mos. ds.

Immediate (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) [signature] M. D.

7/14, 1929 (Address) 1606 E. Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: National Cem — DATE OF BURIAL 7/16 1929

20 UNDERTAKER: Robert Brooks & Son — ADDRESS Calhoun Hollins st

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47645

E 47645

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

1—PLACE OF DEATH

REGISTERED NO. 946

CITY OF BALTIMORE: (No. 709 E. 20th ST., [illegible] WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Edna Jones

(a) RESIDENCE NO. 709 E. 20th ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 7 mos. 2 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clarence K. Jones

6 DATE OF BIRTH (month, day, and year) Dec. 1st 1878

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	50	7	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto. (State or country) Md

PARENTS

10 NAME OF FATHER Alfred S. Clay

11 BIRTHPLACE OF FATHER (city or town) (State or country) New York

12 MAIDEN NAME OF MOTHER Mary R. Reeves

13 BIRTHPLACE OF MOTHER (city or town) Balto (State or country) Md

14 Informant Clarence K. Jones

(Address) 709 E. 20th St.

JUL 15 1929

File

C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 1929

17

I HEREBY CERTIFY, That I attended deceased from May 28 1929 to July 13 1929, that I last saw h[illegible] alive on July 12 1929 and that death occurred, on the date stated above, at 2 10 AM m.

The CAUSE OF DEATH* was as follows:

Acute Ulcerative endo Carditis engrafted upon and old Mitral insufficiency & Aortic[illegible] of Mitral & Tricuspid

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Harry Hyde, M. D.

7/13, 1929 (Address) 1100 E. Chase

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Druid Ridge Cem

DATE OF BURIAL July 15 1929

20 UNDERTAKER Wm J. Gruckner Son

ADDRESS N. & Pa

important. See instructions on back of certificates.

Cor.—10-10-29—A.Co.—100 Bks.

E 47646

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47646

113

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of Baltimore: (No. 917 W. Lexington St. 18-76 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Charles T. Burns

(a) RESIDENCE NO. 917 W. Lexington St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 18 - 1929

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
			25	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Horace Burns

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ga.

12 MAIDEN NAME OF MOTHER Annie Davis

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ga

14 Informant Mrs A. Burns
(Address) 917 W. Lexington St

15 Filed JUL 15 1929 C. HAMPSON JONES, M. D. Registrar

By

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Mes - Colitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zollers M. D.

7/13, 1929. (Address) 2739 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cemetery	July 15, 1929
20 UNDERTAKER	ADDRESS 322 N. Lanvale St
Mrs Kate R. Williams	

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47647

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47647

CERTIFICATE OF DEATH

1852

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. So. Balto. Gen. ST., 24 03 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Johanna Sullens

(a) RESIDENCE NO. 2211 Gough ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 60 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	81 yrs.	?	?	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Widow

(c) Name of employer: No

9 BIRTHPLACE (city or town) (State or country): Ireland

PARENTS

10 NAME OF FATHER Simon Hubbard

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER ? Hubbard

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Mrs. Keye

(Address) 2217 Gough St.

15 Filed JUL 15 1929, 19 HAMPSON JONES, Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12, 1929

17 I HEREBY CERTIFY, That I attended deceased from 6-26, 1929, to 7-12, 1929, that I last saw h[illegible] alive on July 12, 1929, and that death occurred, on the date stated above, at 9 35 P. m.

The CAUSE OF DEATH* was as follows:

Fracture of neck of right femur

Accidental

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac Failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 2211 Gough St 6/26/29.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? X-Ray & Symptoms

(Signed) E. A. Lichtenger, M. D.

, 19 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oakland Cemetery

DATE OF BURIAL: July 16, 1929

20 UNDERTAKER: John A. Maan

ADDRESS 3000 E. Balto St.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47648

CERTIFICATE OF DEATH

90 E 47648

1—PLACE OF DEATH

REGISTERED NO. 1775

CITY OF BALTIMORE: (No. Baltimore City Hosp. ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry Nash

(a) RESIDENCE NO. 412 W. Mulberry ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	68			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Leather Worker

(b) General nature of industry, business, or establishment in which employed (or employer) O.K.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Maryland

PARENTS

10 NAME OF FATHER Henry Nash

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Caroline ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14 Informant Hosp. Record
(Address)

15 Filed 7 13 1929, 19 C. HAMPSON JONES, M. D. Registrar
Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/11/29

17 I HEREBY CERTIFY, That I attended deceased from 6/20, 1929, to 7/11, 1929, that I last saw him alive on 7/11, 1929 and that death occurred, on the date stated above, at 11 30 P. m.

The CAUSE OF DEATH* was as follows:

Senility -

Senile Gangrene left foot

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis, Bronchopneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of 6/23/29

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. L. Lumpkin, M. D.

7/12, 1929 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cemetery

DATE OF BURIAL 7-16-1929

20 UNDERTAKER J. M. Johnson

ADDRESS 1234 Eutaw St.

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 47649

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

REGISTERED NO. E 47649

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Balt City Hospital St. 17-7 Ward) 101-001

2-FULL NAME Henry Williams

(a) RESIDENCE NO. 528 Pine St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	49?			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country)

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant
(Address)

15 Filed ..... 19..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry.) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cirrhosis of Pancreas

Hospital 17 hrs

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary)

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? 528 Pine

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) James M Hudson, M. D.

7/12 1929 (Address) York Road

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND — DATE OF BURIAL: July 15 1929

20 UNDERTAKER: Commissioner Health. — ADDRESS

FEB 15 1929 — WILLIAM H. JONES, M.D.

OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

2270 E 47650

E 47650

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST 24-33 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Theresa Brocato

(a) RESIDENCE No. 702 E Fort Ave ST WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Inf.

If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7/9/29

7 AGE — Years — Months — Days: 2 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Claudo Brocato

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Florence Delforso

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUL 15 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 11 1929

17

I HEREBY CERTIFY, That I attended deceased from July 10 .1929. to July 11 .1929.

that I last saw her alive on July 11 .1929.

and that death occurred, on the date stated above, at 12:35 P m.

The CAUSE OF DEATH* was as follows:

Intracranial Hemorrhage

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary) Prematurity

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Lateral puncture

(Signed) J. C. Goodwin M. D.

9/13. 1929 (Address) J. H. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: JOHNS HOPKINS HOSPITAL — DATE OF BURIAL 19

20 UNDERTAKER — ADDRESS

JUL 15 1929

INSTRUCTIONS: This certificate should be carefully supplied. Any error should be corrected. CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

Zlucinski

22E 3 4423 47651

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

135 E 47651

REGISTERED NO.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST., 7-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mike Zdlinski

(a) RESIDENCE NO. Odenton Md ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if of foreign birth? unknown yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed , 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 1929

17

I HEREBY CERTIFY, That I attended deceased from March 15, 1929, to July 12, 1929, that I last saw him alive on July 12, 1929, and that death occurred, on the date stated above, at 5 A m.

The CAUSE OF DEATH* was as follows:

Pyelonephritis
Cystitis
Wound infection

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Benign Prostatic Hypertrophy (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? At Home

Did an operation precede death? Yes Date of 3/25/29

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) J. M. Smith, M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL JOHNS HOPKINS HOSPITAL DATE OF BURIAL 19

20 UNDERTAKER Consolidated ADDRESS JUL 15 1929

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

JUL 15 1929 C. HAROLD JONES, M. D.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47652

CERTIFICATE OF DEATH

24-101 E 47652

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Club Room 1504 Pennsylvania Ave St. 28 Ward)

2-FULL NAME Henry Williams

(a) RESIDENCE NO. unknown St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	Col	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day and year) about 1884

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
about 45		—		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Junk Dealer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant N. W. Police Record,
(Address)

15 Filed JUL 15 1929 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) July 2nd 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.
The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
(Apoplexy) (duration) yrs. Sudden
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) M. D.
July 3rd 29 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

JUL 15 1929

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

UNIVERSITY OF MARYLAND

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47653

CERTIFICATE OF DEATH

44 V E 47653

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Union Memorial Hospital ST., WARD)

2—FULL NAME Mr. Thomas Mc Cullough

(a) RESIDENCE NO. 2004 Kennedy ave ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Mary Mc Cullough

6 DATE OF BIRTH (month, day, and year) March 25, 1871

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
58	3	18 26	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Office Manager

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) ~~Ireland~~ Baltimore
(State or country)

PARENTS

10 NAME OF FATHER David Mc Cullough

11 BIRTHPLACE OF FATHER (city or town) Ireland
(State or country)

12 MAIDEN NAME OF MOTHER Mary Smith

13 BIRTHPLACE OF MOTHER (city or town) Ireland
(State or country)

14 Informant ~~Deceased~~ Mrs. Thos. Coddington

(Address) 2004 Kennedy Ave

15 Filed JUL 15 1929 19 C. HAYDON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1929, to July 13, 1929

that I last saw h~~im~~alive on July 13, 1929

and that death occurred, on the date stated above, at 6 45 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of stomach & metastasis.

(duration) — yrs. 8 mos. — ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? undetermined

Did an operation precede death? Yes Date of May 16

Was there an autopsy? No

What test confirmed diagnosis? Biopsy.

(Signed) Samuel McLanahan, M. D.

July 13, 1929 (Address) Union Mem. Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cem Mary Mc Wakefield	July 16 1929
20 UNDERTAKER Mary M Wakefield	ADDRESS 501 E 22nd

IMPORTANT—Physician in charge of case is required to fill out and sign this certificate in plain terms, so that it may be easily read; important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47654

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90

E 47654

1—PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO.

CITY OF BALTIMORE: (No. 42-31 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Calvin Bruton

(a) RESIDENCE NO. 1000 Leadenhall ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., If foreign birth? — yrs. — mos. — ds.

important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of --

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	23			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) South Carolina

PARENTS

10 NAME OF FATHER Allen E. Bruton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Venie ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records of the
(Address) Baltimore City Hospitals

15 Filed JUL 15 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 11, 1929, to July 12, 1929 that I last saw h. im alive on July 12, 1929 and that death occurred, on the date stated above, at 9:45 P. m.

The CAUSE OF DEATH* was as follows:

Myocarditis chronic Parenchymatous
Bacterial endocarditis (undetermined)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pericarditis: Bronchopneumonia

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical Course & Autopsy

(Signed) Warren H. Wilson, M. D.

7-14, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Duncan South Carolina

DATE OF BURIAL July 15 1929

20 UNDERTAKER Walter G Spriggs

ADDRESS 39 W. Hamburg St

Spec.—2-29-28—L. F. S.—500 Bks.

E 47655 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47655

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST. 20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Fallin

(a) RESIDENCE NO. Coan, Va ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 20 ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or ~~Divorced, (write the word)~~
Female	White	married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Eugene Fallin

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
44			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Chas E Thomas

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Cecelia —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Eugene Fallin

(Address) Coan Va

15 Filed JUL 15 1929 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/14/29

17 I HEREBY CERTIFY, That I attended deceased from 6/26, 1929, to 7/14/29, 19, that I last saw h alive on 7/14/29, 19, and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Cholelithiasis and Empyema of Gall-bladder

(duration) Unknown abt 1 yr

CONTRIBUTORY (Secondary) Paralytic Ileus

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of Removal of Gall Bladder 7/2/29

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Operation.

(Signed) Luther B. Hodd, M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cem	July 16 1929

20 UNDERTAKER Chas O Mitchell Sons ADDRESS 1900 Eastern Ave

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

E 47656

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

46 E 47656

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 129 West Lee ST. 12-30 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Middleton Smith

(a) RESIDENCE NO. 129 W. Lee ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred - yrs. - mos. - ds. How long in U. S., if foreign birth? - yrs. - mos. - ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

a If married, widowed, or divorced BUSBAND of (or) WIFE of Dr. William S. Smith

6 DATE OF BIRTH (month, day, and year) July 23, 1866

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	62	11	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Not obtainable

PARENTS

10 NAME OF FATHER Ignatius Middleton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not obtainable

12 MAIDEN NAME OF MOTHER Annie Hooper

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not obtainable

14 Informant Dr. Wm. S. Smith

(Address) 129 W. Lee Street

15 Filed ..... 19 ..... Registrar

important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13, 29

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1927 to July 13 1929 that I last saw h alive on July 13 1929 and that death occurred, on the date stated above, at 9 22 P. m.

The CAUSE OF DEATH* was as follows:

Pseudo-mucinous cyst of ovary with abdominal metastases

(duration) 2 yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of Sept 28, 1927 May 5, 1928

Was there an autopsy? No

What test confirmed diagnosis? Microscopic Diagnosis

(Signed) Grant Edward. M. D.

19 (Address) 214 Medical & Sc Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery

DATE OF BURIAL 7/16 19 29

20 UNDERTAKER Henry U. Mears and Son

ADDRESS 805 N. Calvert

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47657

CERTIFICATE OF DEATH.

E 47657

1-PLACE OF DEATH Church Home & Infirmary

CITY OF BALTIMORE: (No.) Broadway & Fairmount (WARD) 29

REGISTERED NO. 100-001

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Helen Penn [Elena Penkauskas]

(a) RESIDENCE NO. 746 N. Henry ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

5a If married, widowed, or divorced
HUSBAND of
or) WIFE of late John T. Penkauskas

6 DATE OF BIRTH (month, day, and year) 1868

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	61			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Wife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lithuania

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithuania

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant John C. Penn

(Address) 746 N. Henry St.

15 Filed JUL 15 1929, 19... C. HARRISON JONES, M. D. Registrar

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 1929

17

I HEREBY CERTIFY, That I attended deceased from 7/2, 1929, to 7/13, 1929, that I last saw h[illegible] alive on 7/13, 1929, and that death occurred, on the date stated above at 1:00 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Lithiasis
Chronic Angitis

(duration) ... yrs. ... mos 14 ds.

CONTRIBUTORY (Secondary) Pneumonia

(duration) ... yrs. ... mos 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 7/9/29 Removal of Gall Stones

Was there an autopsy? no

What test confirmed diagnosis? Clinical & Laboratory

(Signed) Erin B. Wallace M. D.

7/13, 1929 (Address) 1641 W. Carlin St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	July 16 1929
20 UNDERTAKER	ADDRESS
Harry A. Witzke, 1531 N.	Lombard

21

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47658

CERTIFICATE OF DEATH

129

E 47658

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 5616 Mattfeldt Ave ST., 27-54 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary I. Schneider

(a) RESIDENCE NO. 5616 Mattfeldt Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jacob Schneider

6 DATE OF BIRTH (month, day, and year) May 24-1862

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67	1	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Pennsylvania

PARENTS

10 NAME OF FATHER Jacob Michael

11 BIRTHPLACE OF FATHER (city or town) (State or country) Pennsylvania

12 MAIDEN NAME OF MOTHER Yorkstown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Yorkstown

14 Informant Miss. Emma V. Schneider

(Address) 5616 Mattfeldt Ave.

15 Filed JUL 15 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13-1929.

17 I HEREBY CERTIFY, That I attended deceased from June 1, 1929, to July 13 1929

that I last saw h 12 alive on July 13 1929

and that death occurred, on the date stated above, at 10 30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis

(duration) yrs. 1 mos. 13 ds.

CONTRIBUTORY (Secondary) Angina Pectoris

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No What test confirmed diagnosis? Clinical & Clinical

(Signed) Thurman R. Hurst M. D.

7/14 1929 (Address) 2601 Manhattan Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge	July 16 1929.

20 UNDERTAKER Horace F. Burgee ADDRESS 431 Fulton Road

IMPORTANT. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47659

E 47659

REGISTERED NO. ....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Grand Hotel St., 4-25 Ward)

2-FULL NAME David E. Svantesson

(a) RESIDENCE NO. Grand Hotel 417 W. Fayette St. Ward Illegible

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	40			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Brick layer
(b) General nature of industry, business, or establishment in which employed (or employer) Oil
(c) Name of employer

9 BIRTHPLACE (city or town) ....
(State or country) Sweden

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) ....
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ....
(State or country) Unknown

14 Informant U. S. Army
(Address)

15 Filed JUL 15 1929 19.. HARRISON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) July 14 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Revolver wound of head. Suicide

(duration) ....yrs. ....mos. ....ds.

CONTRIBUTORY (Secondary) ....

(duration) ....yrs. ....mos. ....ds.

18 Where was disease contracted If not at place of death? ....

Did an operation precede death? No Date of ....

Was there an autopsy? No

What test confirmed diagnosis? ....

(Signed) Eugene Zell ET, M. D.

7-15, 1929 (Address) 2739 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cem DATE OF BURIAL 7/16 1929

20 UNDERTAKER Robert Brooks & Son ADDRESS Baltimore

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 47660

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

129 E 47660

REGISTERED NO

1-PLACE OF DEATH Baltimore Md

CITY OF BALTIMORE: (No.) U S Marine Hospital (ST.) 4 (WARD)

If death occurred in a hospital or institution give its NAME instead of street and number.

2-FULL NAME Laurence Tull

(a) RESIDENCE NO. 911 East 30th St, (ST.) Balt Md (WARD)
(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. — mos. — ds. How long in U. S., if of foreign birth? — yrs. — mos. — ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary H Tull

6 DATE OF BIRTH (month, day, and year) June 5 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
77		1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Watchman

(b) General nature of industry, business, or establishment in which employed (or employer) Seaman

(c) Name of employer S/S Calvert.

9 BIRTHPLACE (city or town) Md
(State or country)

PARENTS

10 NAME OF FATHER Benjamin F. Tull

11 BIRTHPLACE OF FATHER (city or town) Md
(State or country)

12 MAIDEN NAME OF MOTHER Charlotte Morris

13 BIRTHPLACE OF MOTHER (city or town) Md
(State or country)

14 Informant Self Mary H Tull.
(Address) 911 East 30th St

15 Filed [illegible] 19 [illegible] C. H. JOHNSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 1929

17 I HEREBY CERTIFY, That I attended deceased from April 30, 1927, to July 13, 1929, that I last saw him alive on July 13, 1929, and that death occurred, on the date stated above, at 8:50 P m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis, generalized
Endarteritis obliterans Gangrene

(duration) 7 yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic myocarditis + Nephritis, Bronchopneumonia (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? yes Date of 1927

Was there an autopsy? yes

What test confirmed diagnosis? Examination

(Signed) C. L. Wilmoth, M. D.

1929 (Address) U.S. Marine Hospital Baltimore Md.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery DATE OF BURIAL July 16 1929

20 UNDERTAKER George F. Ruth ADDRESS 1735 Harford

mation should be carefully supplied. CAUSE OF DEATH. In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

125928
E 47661

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47661

CERTIFICATE OF DEATH.

135

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. 8-16 WARD)

2-FULL NAME Charles Llewellyn

(a) RESIDENCE NO. 2315 E. Oliver ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: male

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: unknown

6 DATE OF BIRTH (month, day, and year): 1/30/56

7 AGE: 73 Years 72 Months 7 Days 14 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: machinist - oil

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: unknown

9 BIRTHPLACE (city or town) (State or country): Va

PARENTS

10 NAME OF FATHER: unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant: Records (Address) JOHNS HOPKINS HOSPITAL

15 Filed JUL 15 1929 19 C. Harper Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 14 1929

17 I HEREBY CERTIFY, That I attended deceased from June 3 1929 to July 14 1929 that I last saw h[illegible] alive on July 14 1929 and that death occurred, on the date stated above, at 3 20 P m.

The CAUSE OF DEATH* was as follows:

1 Pyelonephritis

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Benign Prostatic Hypertrophy

(duration) 3 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of Jan 1929

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) E. E. Algire M. D.

19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cem. DATE OF BURIAL: July 17 1929.

20 UNDERTAKER: Geo. L. Ruth ADDRESS: 1735 Hayes

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

BEFORE FILLING IN CERTIFICATE supplies. NOTE should be taken that [illegible]

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47662

CERTIFICATE OF DEATH

E 47662

1—PLACE OF DEATH

REGISTERED NO. 94001

CITY OF BALTIMORE: (No. Cherry Hill 2537 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Kramer

(a) RESIDENCE NO. Cherry Hill Westport WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 85 yrs. 6 mos. 2 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Christopher Kramer

6 DATE OF BIRTH (month, day, and year): Jan 16 1844

7 AGE: Years 85 Months 5 Days 29 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore md

PARENTS

10 NAME OF FATHER: William Drew

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore md

12 MAIDEN NAME OF MOTHER: Sarah Philenders

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Mrs Annie J. Curren

(Address) Westport Balto md

15 Filed ..... 19..... Registrar

L 15129 C. HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 15 1929

17 I HEREBY CERTIFY that I attended deceased from June 10, 1929, to July 15, 1929

that I last saw h— alive on July 15, 1929

and that death occurred, on the date stated above, at 12 M. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Theobald Dram M. D.

(Address) 327 W Mt Royal, 19

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park Cemetery	July 18 1929
20 UNDERTAKER: Fos Sweeden's Son	ADDRESS: 2078 Pa Ave

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47663

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 ✓

E 47663

REGISTERED NO. 23-33

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 46 Wheeling ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Emma K. Schwender.

(a) RESIDENCE NO. 46 Wheeling ST., ... WARD
(Usual place of abode)

Length of residence in city or town where death occurred 34 yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? 38 yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White.	Married.

3a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Max G. Schwender.

6 DATE OF BIRTH (month, day, and year) July, 13, 1880

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	49.		2.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At home.

(b) General nature of industry, business, or establishment in which employed (or employer) .....

(c) Name of employer .....

9 BIRTHPLACE (city or town) Germany.
(State or country)

PARENTS

10 NAME OF FATHER Julius Scholtz/

11 BIRTHPLACE OF FATHER (city or town) Germany.
(State or country)

12 MAIDEN NAME OF MOTHER Pauline Miller.

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Germany.

14 Informant Max G. Schwender.
(Address) 46 Wheeling St.

15 Filed JUL 15 1929, 19.. [illegible] JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15-1929

17 I HEREBY CERTIFY, That I attended deceased from June 18, 1928, to July 15, 1929, that I last saw h alive on July 14, 1929 and that death occurred, on the date stated above, at 3.45 A. m.

The CAUSE OF DEATH* was as follows:

Chronic valvular heart disease

..... (duration) 20 yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Pulmonary oedema

..... (duration) ..... yrs. ..... mos. 3 ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Chas. Kirkwood, M. D.

7/15, 1929 (Address) Mapleaid, Pa Route 2

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill Cem	July 18 1929
20 UNDERTAKER	ADDRESS
H. Howard Evans	38 E. Fort Ave

Fill in plainly, using ink, all items; especially important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47664
1—PLACE OF DEATH

117 ✓ E 47664
REGISTERED NO.

CITY OF BALTIMORE: (No. N.E.cor. Woodbourne & Purdue Avenues ST. 27-48 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Augustus Sievers Hughes Fox

(a) RESIDENCE NO. N.E.Cor. Woodbourne & Purdue Aves ST., WARD Resident
(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. 1 mos. 20 ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) May-25-1912

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	17	1	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) None

(c) Name of employer None

9 BIRTHPLACE (city or town) (State or country) Baltimore Maryland

PARENTS

10 NAME OF FATHER Harold Douglass Fox

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Maryland

12 MAIDEN NAME OF MOTHER Augustus L. S. Hughes

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Maryland

14 Informant Mrs. Harold D. Fox

(Address) Woodbourne & Purdue Aves.

15 Filed JUL 15 1929 C. HARRISON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15, 1929

17 I HEREBY CERTIFY, That I attended deceased from March 20, 1929, to July 15, 1929, that I last saw h[illegible] alive on July 14, 1929 and that death occurred, on the date stated above, at 7.45 A.M.

The CAUSE OF DEATH* was as follows:

Valvular Heart Disease
mitral
about 4 months
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Inflammatory Rheumatism
about 4 months
(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Has had several previous attacks

Did an operation precede death? Yes Date of March 20/29

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Henry Dr Bayley, M. D.

July 15 1929 (Address) 2805 N. Calvert St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery — DATE OF BURIAL July 17 1929

20 UNDERTAKER STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Successor) — ADDRESS 108 W. NORTH

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47665 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47665

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Mt Hope Retreat ST.) (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rose Welch

(a) RESIDENCE NO. 1707-16th St Wash. D.C. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos 24 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Single

6 DATE OF BIRTH (month, day, and year) ? ? 1865

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	64	Unknown		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Stenographer

(b) General nature of industry, business, or establishment in which employed (or employer) Government

(c) Name of employer U. S.

9 BIRTHPLACE (city or town) Hutleton (State or country) N.Y.

PARENTS

10 NAME OF FATHER John Welch

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country) Ireland

12 MAIDEN NAME OF MOTHER Sarah McGuen

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country) Ireland

14 Informant Mt Hope Records

(Address) Mt Hope Retreat.

15 Filed ....., 19 ..... C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14. 1929

17 I HEREBY CERTIFY, That I attended deceased from June 26, 1929, to July 14 1929, that I last saw her alive on July 13 1929 and that death occurred, on the date stated above, at 9.30 a m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis
Cardiac Dilitation

Unknown (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Manic-Depressive Psychosis

— (duration) — yrs 2 mos — ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Milton P. Ball M. D.

, 19 (Address) Mt Hope Retreat.

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Olivet Cemetery, Washington, D.C. DATE OF BURIAL July 16 1929

20 UNDERTAKER Stewart & Brown Co. ADDRESS 102 W. North Ave.

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47666

1-PLACE OF DEATH

CERTIFICATE OF DEATH

23 E 47666

REGISTERED NO.

City of Baltimore: (No. Mercy Hospital. St. 5-8 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME George W. Yost.

(a) RESIDENCE NO. 423 East St. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 21 yrs. 5 mos. 11 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of ---

6 DATE OF BIRTH (month, day, and year) February 4, 1908.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	21	5	11	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Chauffeur.
(b) General nature of industry, business, or establishment in which employed (or employer) Horn Ice Cream Co.
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

10 NAME OF FATHER Levi Yost.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Maryland.

12 MAIDEN NAME OF MOTHER Fannie B. Hooper.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Virginia.

14 Informant Fannie E. Yost. (mother)
(Address) 423 East St.

15 Filed JUL 15 1929 E. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Encephalitis.

(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?
Did an operation precede death? No. Date of
Was there an autopsy? No.
What test confirmed diagnosis? Hospital Diagnosis.
(Signed) Otto M. Heinrandt, M. D.
7/15 1929 (Address) 1014 S. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Martinsburg, West Virginia — DATE OF BURIAL July 17, 1929

20 UNDERTAKER E. Leroy Stifflew & Inc. — ADDRESS 125 E. North Ave.

...tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47667

32 E 47667

1-PLACE OF DEATH

City of Baltimore: (No. Johns Hopkins Hospital St. 7-16-29 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry Calvin Walker

(a) RESIDENCE NO. 920 Rosedale St St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 1/1928

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	1	2	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto. Md.

PARENTS

10 NAME OF FATHER Earl Walker

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto., Md.

12 MAIDEN NAME OF MOTHER Alice E. Brightwell

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto., Md.

14 Informant Earl Walker
(Address) 920 Rosedale St

15 Filed ..... 19 ..... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Tubercular Meningitis

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? At Hopkins

What test confirmed diagnosis?

(Signed) J. H. Cutter M. D.

7/14/29 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodbine, Howard Co. DATE OF BURIAL July 16, 29

20 UNDERTAKER Bernard A. Fink ADDRESS 734 Poplar Grove St

JUL 15 1929 H. [illegible] JONES, M. D.

N. B.—IN FILLING OUT THIS CERTIFICATE, WRITE PLAINLY WITH PEN AND INK. AGE should be carefully supplied. OCCUPATION should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 47668

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47668

CERTIFICATE OF DEATH

188-10-3

1-PLACE OF DEATH

City of Baltimore: (No.) Union Memorial Hosp. St., (Ward) 13-57

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Wm Oscar Martin

(a) RESIDENCE NO. 3500 Kirkwood Rd St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	W	Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mrs O. Martin

6 DATE OF BIRTH (month, day, and year) July 27 1877

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
51	51	11	16	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Mechanic
(b) General nature of industry, business, or establishment in which employed (or employer) Automobile
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto md

PARENTS

10 NAME OF FATHER Wm M. Martin

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto md

12 MAIDEN NAME OF MOTHER Julia Jones

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto md

14 Informant Barbara Martin
(Address) 3500 Kirkwood Rd

15 Filed ..... 19 ..... C. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest
(Inquest, autopsy or inquiry) find that said deceased came to h death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fracture of skull
Accidentally falling from auto
sunny found when before sally
when adjust
(duration) yrs. mos. ds.
CONTRIBUTORY (Secondary) Cerebral Hemorrhage
(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? Falls Road

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Xray

(Signed) T J Frantz, M. D.

(Address) 2939 McElderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Marys Hunt	19
20 UNDERTAKER	ADDRESS
Ehenow	

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—12-9-25—A Co.—200 Blks.

E 47669

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47669

CERTIFICATE OF DEATH.

74-601

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 3648 Ash. St. 13 Ward)

2-FULL NAME Charles C Green

(a) RESIDENCE NO. 3648 Ash. St. 13 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced. (write the word)
Male	white	widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Late Ella Green

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	68 (68)			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Mill Hand

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) md

(State or country)

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)

(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Unknown

14 Informant Cora Montgomery

(Address) 3648 Chestnut ave.

15 Filed JUL 16 1929, 19 [illegible] Registrar

[illegible] CHAMPION, M. D.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-14 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Jury (Inquest, autopsy or inquiry.) were fiud that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY (Secondary)

(duration) .....yrs. .....mos. .....ds.

(Signed) [illegible] M. D.

(Coroner)

7/15 1929 (Address) 2032 Orland ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death.....yrs.,.....mos.,.....ds. In the State.....yrs.,.....mos.,.....ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL Date of Burial

Westminster July 19 1929

20 UNDERTAKER ADDRESS

Edwin H. Eberhardt 2661

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks. Sister Mary Euphrasia Andre

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47670 90 E 47670

CERTIFICATE OF DEATH

1—PLACE OF DEATH REGISTERED NO. 1045

CITY OF BALTIMORE (No. Saint Francis St., 1 Ward) (If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sister Mary Euphrasia Andre

(a) RESIDENCE NO. Chase and Brentwood Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 41 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F.	C.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) November 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	88			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sister

(b) General nature of industry, business, or establishment in which employed (or employer) Needle Work.

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) New Orleans La.

PARENTS

10 NAME OF FATHER Vincent Andre

11 BIRTHPLACE OF FATHER (city or town) (State or country) New Orleans

12 MAIDEN NAME OF MOTHER Julia Hardie

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New Orleans La.

14 Informant Estate Sisters Presentation (Address) Chase & Brentwood

15 Filed JUL 16 1929, 19 C. HAMPSON JONES, Registrar By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14, 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 31, 19.., to July, 19 29, that I last saw her alive on July 10, 19 29 and that death occurred, on the date stated above, at 10.25 a. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis
Dilated heart

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Usual symptoms

(Signed) Geo. F. Wellman, M. D.

July 15, 1929 (Address) 1128 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
New Cathedral	July 16, 1929
UNDERTAKER	ADDRESS
Wm. R. G. Elliott	1725 E. Baltimore

OF DEATH is prerequisite to burial permit, so that it may be issued promptly. important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 47671

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47671

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St. 4-30 Ward)

2-FULL NAME James V Beatty

(a) RESIDENCE NO. Pasadena, Md St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mildred L. Beatty

6 DATE OF BIRTH (month, day, and year) May 22 - 1899

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	30	1	22	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Lumberman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER Wm Beatty

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Lunnie Scrivner

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Mrs. Mildred Beatty
(Address) Pasadena, Md.

15 Filed ..... 19..... C. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

2 Nd. & 3rd degree burns over entire body
Accidental Death

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Pasadena Md

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Feller M. D.

7/15 1929 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mazotty Church Cem

DATE OF BURIAL JULY 19 1929

20 UNDERTAKER John F Denny

ADDRESS 715 E 25th

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JUL 16 1929

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47672 E 47672

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of Baltimore: (No. University Hospital St., 4-30 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William James Beatty

(a) RESIDENCE NO. Pasadena, Md St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mns. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Corg I. Beatty

6 DATE OF BIRTH (month, day, and year) Feb 28-1888

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	41	4	14	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Lumberman
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Self

9 BIRTHPLACE (city or town)
(State or country) Md

PARENTS

10 NAME OF FATHER Wm. Beatty

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Emma Scrivnor

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Mrs. Wm. J. Beatty
(Address) Pasadena, Md

15 Filed JUL 16 1929, 19 Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
2nd. & 3rd. Degree burns over Entire Body.
Accidental Death

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Pasadena, Md

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Eugene Seifert, M. D.

7/15, 19 29 (Address) 739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Church Cem. DATE OF BURIAL July 17 1929

20 UNDERTAKER John F. Denny ADDRESS 715 Light St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JUL 16 1929

Spec.—2-29-28—L. F. S.—500 Bks.

E 47673 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

4 57 E 47673

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital 4-30 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Richard T. Ford.

(a) RESIDENCE NO. Lutheran Heights ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Ursula E. Ford

6 DATE OF BIRTH (month, day, and year) Mar 1 1864

7 AGE Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
65	4	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Prince George Co Md

10 NAME OF FATHER Not known

11 BIRTHPLACE OF FATHER (city or town) (State or country) Not known

12 MAIDEN NAME OF MOTHER Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Not known

PARENTS

14 Informant Thomas Ford (son)

(Address) Lutheran Heights

Filed JUL 16 1929, 19 HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13, 1929.

17 I HEREBY CERTIFY, That I attended deceased from 7/12, 1929, to 7/13, 1929 that I last saw h. alive on 7/13, 1929 and that death occurred, on the date stated above, at 10 A. m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) ? UNKNOWN yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis, Cellulitis R. Foot

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical & Autopsy

(Signed) Luther E. Leale M. D.

19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Ford-Home Cemetery Co.

DATE OF BURIAL July 16 1929

20 UNDERTAKER John F. Denny

ADDRESS

Important. See instructions on back of certificates.

L 16 1929

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47674

CERTIFICATE OF DEATH

× 49

E 47674

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Baltimore City Hosp. WARD) 14-20

2—FULL NAME Frances Hines

(a) RESIDENCE NO. 1410 Madison Ave. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. 4 mos. — How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem.	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of W. J. Hines

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	50?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. C.

PARENTS

10 NAME OF FATHER Thos. Hanson

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. C.

12 MAIDEN NAME OF MOTHER Jane Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. C.

14 Informant Hospital Record

(Address)

15 Filed JUL 16 1929, 19 C. HAMPSON JONES, M. D. Registrar

Pat. OKG

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/14/29

17 I HEREBY CERTIFY, That I attended deceased from 5/14, 1929, to 7/14, 1929

that I last saw h alive on 7/14, 1929

and that death occurred, on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

Destruction 9th dorsal vertebra probably malignant - Paralysis of trunk and lower extremities

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Decubitus ulcers of back Bronchopneumonia, (duration) yrs. mos. 12 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L. C. Swinehart, M. D.

7/14, 1929 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Franklin Va.

DATE OF BURIAL 7/18 1929

20 UNDERTAKER Chas. T. Cooper

ADDRESS 514 N. Eutaw St

IMPORTANT. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

Dvorak

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47675 — E 47675

CERTIFICATE OF DEATH.

146

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 6-9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Rosa Dvorak

(a) RESIDENCE NO. 1935 Orleans ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 27 yrs. 9 mos. 11 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): married

5a If married, widowed, or divorced (or) WIFE of: Charles B Dvorak

6 DATE OF BIRTH (month, day, and year): 10/30/01

7 AGE — Years: 27 — Months: 9 — Days: 11 — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: at home

9 BIRTHPLACE (city or town) (State or country): Md

PARENTS

10 NAME OF FATHER: Wm Higgins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Mary Morley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

15 Date, 19 C. HAMPSON JONES, M. D. Registrar

UL 16 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 14 1929

17

I HEREBY CERTIFY, That I attended deceased from July 1, 1929, to July 14, 1929, that I last saw her alive on July 14, 1929, and that death occurred, on the date stated above, at 1:20 P. m.

The CAUSE OF DEATH* was as follows:

Septicemia, puerperal

(duration) yrs. mos 15 ds.

CONTRIBUTORY (Secondary): none

(duration) yrs. mos ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Franklin F Snyder M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Hill Cem — DATE OF BURIAL: July 17 1929

20 UNDERTAKER: John Merrick — ADDRESS: 200 E Oriole

MEDICAL RECORD OF CAUSE OF DEATH. Should be carefully supplied. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47676

CERTIFICATE OF DEATH

E 47676

REGISTERED NO. 94708

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1217 N. Caroline St. 8-13 Ward)

2-FULL NAME Joseph M. Pariser

(a) RESIDENCE NO. 1217 N. Caroline St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	white	married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Lillian Pariser

6 DATE OF BIRTH (month, day, and year) June 6 1882

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	47	1	9	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Real Estate
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto., Md.

PARENTS

10 NAME OF FATHER Jacob Pariser

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Bailey xxxxxx

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Lillian Pariser
(Address) 1217 N. Caroline St

15 Filed JUL 16 1929 C. HAMPSON JONES, M. D. Registrar
Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15/29

17 I HEREBY CERTIFY, That I took charge of the remains deserbed above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to M. D. death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) [signature] M. D.

7/15/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Herring Run	July 11 1929
20 UNDERTAKER S Levinson Bro	ADDRESS 1215 E Balto St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 47677

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

101-001

E 47677

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Provident Hosp. St. 14-26 (Ward)

2-FULL NAME Geo. Gosnell

(a) RESIDENCE NO. 2010 Penna. Ave. Ward

(Usual place of abode)

Length of residence in city or town where death occurred 29 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col.	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of No.

6 DATE OF BIRTH (month, day and year) 1900

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	29			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore
(State or country)

PARENTS

10 NAME OF FATHER August Gosnell

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Gibbs

13 BIRTHPLACE OF MOTHER (city or town) York
(State or country)

14 Informant Mary Bowyer
(Address) 2010 Penna Ave.

15 Filed ..., 19...

JUL 16 1929 C. HARRISON JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) July 13th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest, autopsy or inquiry.

thereon and from the evidence obtained by said Autopsy Autopsy or inquiry find that said deceased came to Inquest, autopsy or inquiry death on the day stated above.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia (duration) ... yrs. ... mos. 2 ds.

CONTRIBUTORY (Secondary) Hypertrophy of Liver (duration) ... yrs. 3 mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Yes

(Signed) H. Blank, M. D.

July 14th 1929 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	July 16 19 29
20 UNDERTAKER Thomas E. Kelson.	ADDRESS 1303 Pennsylvania Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47678

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

23

E 47678

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1116 Hope Retreat ST., 1-1 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary C. Kafka

(a) RESIDENCE NO. 913 S. Decatur ST., ... WARD
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Frank Kafka

6 DATE OF BIRTH (month, day, and year): Nov 28 1885

7 AGE: 43 Years 43 | Months 9 | Days 16 | If LESS than 1 day, ... hrs. or ..... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housekeeper

(b) General nature of industry, business, or establishment in which employed (or employer): Housework

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Joseph Jones

11 BIRTHPLACE OF FATHER (city or town) (State or country): Austria

12 MAIDEN NAME OF MOTHER: Emma Bussey

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Austria

14 Informant: Frank Kafka

(Address): 913 S. Decatur

15 Filed ..... 19..... C. HAMPSON JONES, M. D. Registrar

161929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7/14/29

17 I HEREBY CERTIFY, That I attended deceased from Jan 1929, 19..... to July 14, 19 29

that I last saw her alive on July 14, 19 29

and that death occurred, on the date stated above, at 7.30 P. m.

The CAUSE OF DEATH* was as follows:

Post Pelvic Cellulitis

Exhaustion

Hemiplegia.

..... (duration) 4 yrs. 2 mos. ..... ds.

CONTRIBUTORY (Secondary): Cerebral Embolism

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?.....

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? Findings

(Signed) D. Duncan Wallace M.D.

, 19 (Address) 331 Cathedral St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	July 17 1929
20 UNDERTAKER	ADDRESS
George A. Weber	205 [illegible]

important. See instructions on back of certificates.

E 47679

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47679

CERTIFICATE OF DEATH

90

REGISTERED NO. 13-59

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH
City of Baltimore (No.) Lunch Room (Carey & Gold St.) (Ward)

2-FULL NAME Eugene Bell

(a) RESIDENCE NO. 2528 Druid Hill St., Ward
(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Grace Bell

6 DATE OF BIRTH (month, day, and year) Feb 25 1902

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	27	4	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Auto Mechanic
(b) General nature of industry, business, or establishment in which employed (or employer) 086
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Geo Bell

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Martha Boyer

13 BIRTHPLACE OF MOTHER (city or town) Md.
(State or country)

14 Informant Beatrice Brown
(Address) 2525 Druid Hill

Filed JUL 16 1929 C. HAMPSON JONES, M. D.
Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 12 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Mitral Regurgitation

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 2528 Druid Hill Ave
Did an operation precede death? No Date of
Was there an autopsy? Yes
What test confirmed diagnosis? Regular

(Signed) J. Chatworth Coroner, M. D.
July 12 1929 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem DATE OF BURIAL July 16 29

20 UNDERTAKER Samuel A Wensley ADDRESS 1600 N Bridle

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 47680

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47680

CERTIFICATE OF DEATH.

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 616 Pitcher ST. 14-20 WARD)

2-FULL NAME Alexander Phillips

(a) RESIDENCE NO. 616 Pitcher ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Georgia Phillips

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Calvert Co (State or country) Md

PARENTS

10 NAME OF FATHER Peter Phillips

11 BIRTHPLACE OF FATHER (city or town) Calvert Co (State or country) Md.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Georgia Phillips (Address) 616 Pitcher St

15 Filed JUL 16 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 1929

17

I HEREBY CERTIFY, That I attended deceased from June 20, 1929, to July 13, 1929, that I last saw h[illegible] alive on July 13, 1929, and that death occurred, on the date stated above, at 9:20 P m.

The CAUSE OF DEATH* was as follows:

Chronic Interstitial Nephritis

(duration) 1 yrs. mos ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. 5 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward Chas Frey, M. D.

7-17-1929 (Address) 1928 Penna Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn Cem DATE OF BURIAL July 17 1929

20 UNDERTAKER Samuel Kemsley & Bro ADDRESS [illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 47681

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47681

CERTIFICATE OF DEATH.

11-002

1-PLACE OF DEATH

CITY OF BALTIMORE—No. 803 Harlem Av ST. 17-23 WARD)

REGISTERED No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Emma J Williams

(a) RESIDENCE No. 803 Harlem Av ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 51 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Archer Wms

6 DATE OF BIRTH (month, day, and year): January 28 1878

7 AGE: Years 51 Months 5 Days 14 If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Littleton P. Johnson

11 BIRTHPLACE OF FATHER (City or town) (State or country): Md

12 MAIDEN NAME OF MOTHER: Clarissa Hughes

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Md

14 Informant: Archer Williams

(Address) 803 Harlem Ave

Filed JUL 16 1929 C. HAMPSON JONES, M.D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 17, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 10, 1929 to July 12, 1929 that I last saw h alive on July 12, 1929 and that death occurred, on the date stated above, at 11 P m

The CAUSE OF DEATH* was as follows:

Acute Parenchymatous Nephritis.

(Duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Influenza

(duration) mos. 14 ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J B Hughes M. D.

(Address) 1413 E. Hill Av

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem DATE OF BURIAL July 16 29

20 UNDERTAKER: Samuel Wenskus ADDRESS Biddle

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact Statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 17682 HEALTH DEPARTMENT—CITY OF BALTIMORE 7-001 E 17682

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 5 N. Bradford ST., 610 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Stabb

(a) RESIDENCE NO. 5 N. Bradford ST., 6 WARD
(Usual place of abode)

Length of residence in city or town where death occurred 57 yrs. 3 mos. 29 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of Joseph Stabb.

6 DATE OF BIRTH (month, day, and year) March 15th 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	57	3	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John Schlee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Gaugler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Joseph Stabb (Address) 5 N. Bradford St

Filed JUL 16 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14th 1929

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1928 to July 14, 1929 that I last saw h[illegible] alive on July 14, 1929 and that death occurred, on the date stated above, at 1:30 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene L. Pearson M. D.

July 15, 1929 (Address) 514 Druid Park

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cem	July 17, 1929
20 UNDERTAKER Lilly & Sons	ADDRESS 409 S. Wolfe St

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47683

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47683

CERTIFICATE OF DEATH

129

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 700 S. Clinton ST. 701 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Joseph J. Elbertth

(a) RESIDENCE NO. 700 S. Clinton ST. 26 WARD
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. 9 mos. 21 ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of Anna M. Elbertth.

6 DATE OF BIRTH (month, day, and year) Sept 24th 187

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
50	9	21	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Grocery Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Own

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER August Elbertth

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna Ritter

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Anna M. Elbertth

(Address) 700 S. Clinton St.

Filed JUL 16 1929 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15th/29

17 I HEREBY CERTIFY, That I attended deceased from 5/3/29, 19..., to ..., 19..., that I last saw h... alive on 5/15/29, 19..., and that death occurred, on the date stated above, at 4.6 a. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial Nephritis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Uraemia & Cardiac dilatation

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Gunell, M. D.

(Address) 633 S. Conkling

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Buried Mt. Carmel Cemetery	July 18 1929
20 UNDERTAKER Lily & Julian Inc	ADDRESS 403 S. Wolfe St

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47684

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47684

CERTIFICATE OF DEATH

1—PLACE OF DEATH Hebrew Home for Aged 90

REGISTERED NO.

CITY OF BALTIMORE: (No. 2800 E. Baltimore ST. 27-36 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sarah Arhesman

(a) RESIDENCE NO. 4413 Pimlico Road ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if foreign birth? 23 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Barel Arhesman

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 82 | Months — | Days — | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Jack Lewis

(Address) 1439 E Balt St

Filed JUL 16 1929

C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 16/29

17 I HEREBY CERTIFY, That I attended deceased from June, 1929, to July 16, 1929, that I last saw h[illegible] alive on July 16, 1929, and that death occurred, on the date stated above, at 1 p m.

The CAUSE OF DEATH* was as follows:

myocardial insufficiency

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary): arteriosclerosis

(duration) 15 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible] M. D.

, 19 (Address) 1800 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Hebrew Rosedale — DATE OF BURIAL: July 16 19 29

20 UNDERTAKER: Jack Lewis — ADDRESS: 1439 E Balt St

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

17685 — 31 — 8 17685

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No.) Balt City Hospital St., (or Hospital, or Institution) (Ward)

2-FULL NAME Elsie Johnson

(a) RESIDENCE NO. 1852 Pennsylvania Ave Ward

(Usual place of abode)

Length of residence in city or town where death occurred 38 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1891

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	38			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) General
(c) Name of employer Do not know

9 BIRTHPLACE (city or town) Balto City
(State or country)

PARENTS

10 NAME OF FATHER John Johnson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md

12 MAIDEN NAME OF MOTHER Harriet Brown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Annie Hughes
(Address) 1852 Pennsylvania Ave

15 Filed JUL 16 1929 Harry Jones M. D.
Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Nephritis
(2 hrs at Hospital)

(duration) not known yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? No Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) James M Fenton M. D.

7/15. 1929 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: UNIVERSITY OF MARYLAND — DATE OF BURIAL 19

20 UNDERTAKER Undertaker Means. — ADDRESS

JUL 16 1929

For Wm. F. Roeder

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

Miller

HEALTH DEPARTMENT—CITY OF BALTIMORE

29-001

29 S 17685

17685

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Hopkins Hospital St., 8-17 Ward)

2-FULL NAME George Myers Miller

(a) RESIDENCE NO. 1725 Ellsworth St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
male	black	single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec 17/1916

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
12	13	6	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work School
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Balto.
(State or country) Md.

PARENTS

10 NAME OF FATHER John Myers

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Md.

12 MAIDEN NAME OF MOTHER Nancy Myers

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Md

14 Informant Nancy Myers
(Address) 1725 Ellsworth St

15 Filed ..... 19.... CLAMSON JONES, M.D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14/29

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Tetanus in hand 1
(Accidently shot himself with toy blank cartridge pistol July 4th 1929)
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
(duration) yrs. mos. ds.

18 Where was disease contracted
If not at place of death?
Did an operation precede death? Date of
Was there an autopsy? no
What test confirmed diagnosis? Clinical
(Signed) J. S. M. Owen, M. D.
7/15/29 (Address) 500 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Jamaica Va.	July 16 1929
20 UNDERTAKER	ADDRESS
Mrs. R. G. Elliott	1727 Ashland Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 47687

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

129 E 47687

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 1003 Waldo St., 7-4 Ward)

2-FULL NAME Annie Kane

(a) RESIDENCE NO. 1003 Waldo St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	Black	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Charles Kane

6 DATE OF BIRTH (month, day, and year) Unknown 1879

7 AGE	Years	Months	Days	IF LESS than 1 day hrs or min.
	50			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Domestic
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Cambridge
(State or country) Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) "
(State or country) Unknown

12 MAIDEN NAME OF MOTHER "
Unknown

13 BIRTHPLACE OF MOTHER (city or town) "
(State or country) Unknown

14 Informant Charles Kane
(Address) 1003 Waldo St

15 Filed ..... 19.... Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:

Cardiac Valvular Insufficiency

(duration) yrs. 9? mos. ds.

CONTRIBUTORY (Secondary) Chr. Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Dr. D. E. Fisher

(Signed) [illegible] M. D.

7/15/29 19 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Calvary	June 19 29
20 UNDERTAKER Mrs. W. A. Elliott	ADDRESS 722 Eastern Ave.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JUL 16 1929

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

52

E 17688
1—PLACE OF DEATH

E 17688
REGISTERED NO.

CITY OF BALTIMORE: (No. 1500 Belt St. ST. 24-34 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John T. Sprigg

(a) RESIDENCE NO. 1500 Belt St ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Louisa N. Moxley

6 DATE OF BIRTH (month, day, and year) Oct. 28 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	68	8	17	16

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work B & O R. R.

(b) General nature of industry, business, or establishment in which employed (or employer) 07

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Frederick Co. Md.

PARENTS

10 NAME OF FATHER Samuel N. Sprigg

11 BIRTHPLACE OF FATHER (city or town) Md.
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

14 Informant Mrs. John T. Sprigg
(Address) 1500 Belt St.

15 Filed JUL 16 1929 Per [illegible] WILLIAM H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14-1929

17 I HEREBY CERTIFY, That I attended deceased from March 10. 1929. to July 14. 1929.
that I last saw h alive on July 14. 1929
and that death occurred, on the date stated above, at 5 P. m.
The CAUSE OF DEATH* was as follows:

Arthritis (Spinal) Chronic

CONTRIBUTORY (Secondary) Injury to back caused by lifting heavy object (duration) yrs. 4 mos. 6 ds.

18 WHERE was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) C Mitchell M. D.
1/16. 1929 (Address) 1279 William H

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Lorraine Cemetery — DATE OF BURIAL 7/17 1929

20 UNDERTAKER J. Few McCully — ADDRESS 130 E. Fort

Spec.—1-12-23—M&T—500 Blks.

E47689. HEALTH DEPARTMENT—CITY OF BALTIMORE E47689

CERTIFICATE OF DEATH. 161-002

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2035 Booth ST. 11-28 WARD)

2-FULL NAME Robert LeRoy Penahan Jr

(a) RESIDENCE NO. 2035 Booth St ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male

4 COLOR OR RACE White

5 Single, Married, Widowed, or Divorced, (write the word) —

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 7/16-29

7 AGE

Years	Months	Days	If LESS than 1 day 3 hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Robert LeRoy Penahan

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Celia M. Conkling

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Robert Penahan
(Address) 2035 Booth St

15 Filed JUL 17 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/16 1929

17 I HEREBY CERTIFY, That I attended deceased from 7/16, 1929, to 7/16, 1929

that I last saw him alive on 7/16, 1929

and that death occurred, on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:

Asphyxia Pallida

(duration), yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Thos A Ashman, M. D.

(Address) 2105 N Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cem

DATE OF BURIAL July 18 1929

20 UNDERTAKER John Ulrich

ADDRESS 2008 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Louise Hayes

E 47690

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 17690

1—PLACE OF DEATH University Hospital

REGISTERED NO.

CITY OF BALTIMORE: (No. 14-27 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Louise Hayes

(a) RESIDENCE NO. 1507 W. Saratoga ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Joseph Hayes

6 DATE OF BIRTH (month, day, and year) Autumn 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	35	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Usa

PARENTS

10 NAME OF FATHER Simon Pollock

11 BIRTHPLACE OF FATHER (city or town) (State or country) Usa

12 MAIDEN NAME OF MOTHER Nettie —

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Usa

14 Informant Joseph Hayes

(Address) 1507 W. Saratoga

15 Filed JUL 17 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-17-29

17

I HEREBY CERTIFY, That I attended deceased from 7-5, 19 29, to 7-14, 19 29

that I last saw h alive on July 14, 19 29

and that death occurred, on the date stated above, at 11:5 P m.

The CAUSE OF DEATH* was as follows:

Right Tubo ovarian abscess
Phlebitis pneumococcal

CONTRIBUTORY (Secondary) Intestinal Obstruction (duration) yrs. 4 mos. ds.

18 Where was disease contracted if not at place of death? (duration) yrs. mos. 3 ds.

Did an operation precede death? Yes Date of 7-9-29

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) E. F. Peters M. D.

, 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary — DATE OF BURIAL July 19 29

20 UNDERTAKER John H Toadvine — ADDRESS 1027 Fan

important. See instructions on back of certificates.

JUL 17 1929

Spec.—2-29-28—L. F. S.—500 Bks.

E 17691

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17691

CERTIFICATE OF DEATH

155

1—PLACE OF DEATH St Joseph's Hospital REGISTERED NO.

CITY OF BALTIMORE: (No. Caroline & Lutz ST. S B-4 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Stella Michalski

(a) RESIDENCE NO. 624 S. Bond St ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) March 13-26

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	3	4	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore

PARENTS

10 NAME OF FATHER Stanislaw Michalski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Wladyslawa Holkowska

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Stanislaw Michalski

(Address) 624 S Bond

15 Filed 1929 C. HAMPSON JONES, M. D. Registrar

Par

7 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16, 1929

17 I HEREBY CERTIFY, that I attended deceased from July 3, 1929, to July 16, 1929

that I last saw her alive on July 16, 1929

and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Osteomyelitis of Jaw

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Septicaemia

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of July 10, 1929

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) V. Mecura, M. D.

(Address) St. Joseph's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	July 17 1929
20 UNDERTAKER F W Orazewski	ADDRESS 1930 Eastern Ave

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47692

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

90 E 47692

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1317 Eutaw Pl ST. 1-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Stanley J. Lewis

(a) RESIDENCE NO. 1317 Eutaw Pl. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Geraldine F. Melson Lewis

6 DATE OF BIRTH (month, day, and year) Oct. 18. 1850

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
78	8	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Produce Solicitor Commission 86

(b) General nature of industry, business, or establishment in which employed (or employer) House Agency Manager

(c) Name of employer Geo. Allison Co. N.Y.

9 BIRTHPLACE (city or town) (State or country) Lee Mont Va.

PARENTS

10 NAME OF FATHER Levin D. Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lee Mont Va.

12 MAIDEN NAME OF MOTHER Mary Ann Melson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lee Mont Va.

14 Informant Dr D. W. Lewis

(Address) Middletown Del.

15 Filed 1 7 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17. 1929

17 I HEREBY CERTIFY, That I attended deceased from April 20, 1929, to July 17, 1929, that I last saw him alive on July 17, 1929 and that death occurred, on the date stated above, at 2 00 a m.

The CAUSE OF DEATH* was as follows:

Generalized Atherosclerosis, Chronic Myocarditis, Senile Gangrene Both Feet (non diabetic)

(duration) yrs. 5 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Florida

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) W. Magruder M. D.

, 19 (Address) 521 Med Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Cause, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkesley Va	July 18 1929
20 UNDERTAKER	ADDRESS
James B Hynes	1324 Eutaw Pl

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 47693

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47693

CERTIFICATE OF DEATH

74-001

1-PLACE OF DEATH

City of Baltimore: (No. Sinia Hospital St. 15-68 Ward)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Morris Goldberg

(a) RESIDENCE NO. 1633 N. Bentelow Street St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth 40 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Katie Goldberg

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	55			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Retired Merchant
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Russia

PARENTS

10 NAME OF FATHER Louis Goldberg

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Russia

12 MAIDEN NAME OF MOTHER Unkown

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Russia

14 Informant Samuel Scherr
(Address) 1633 N. Bentelow St

15 Filed JUL 17 1929 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/16/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:
Cerebral Apoplexy

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Gen'l Arteriosclerosis

unknown (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? .....

(Signed) J. T. Rowe M. D.

7/17/29 (Address) 508 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Rosedale Cem — DATE OF BURIAL July 17 1929

20 UNDERTAKER Jack Lewis — ADDRESS 1439 E. Baltimore St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.–7-17-26—A Co.—200 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47694

E 47694 REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 320 S. Fulton Ave St.) 19-24 (Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Wm. J. Wells Jr

(a) RESIDENCE NO. 320 S. Fulton St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Oct. 24 1928

7 AGE: Years 9 Months 10 Days 20 IF LESS than 1 day hrs. or min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer

9 BIRTHPLACE (city or town): Baltimore

(State or country)

PARENTS

10 NAME OF FATHER Wm J. Wells

11 BIRTHPLACE OF FATHER (City or town): Md

(State or country)

12 MAIDEN NAME OF MOTHER Fredericka Langer

13 BIRTHPLACE OF MOTHER (city or town): Md

(State or country)

14 Informant Lena Wells

(Address) 320 S. Fulton Ave.

15 Filed JUL 17 1929 G. HAMPSON JONES, M. D. Registrar

By —

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 14 1929

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1929, to July 14, 1929, that I last saw h. alive on July 14, 1929, and that death occurred, on the date stated above, at 10:30 a. m.

The CAUSE OF DEATH* was as follows:

Anaemia & Convulsions

30

Fever

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Rachitis

(duration) yrs. 3 mos. ds.

18 Where was disease contracted Home

if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Howard Kahn M. D.

7/16/1929 (Address) 2027 Druid

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Loudon Park Cemetery — Date of Burial July 17 1929

20 UNDERTAKER Charles. W. Dill. — ADDRESS 3609 Fredk, Ave.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 47695

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47695

CERTIFICATE OF DEATH

188-103

1-PLACE OF DEATH

City of Baltimore: (No. West Baltimore General Hosp St. 15-61 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Harry Rosen

(a) RESIDENCE NO. 2801 Springdale Ave St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 16 yrs. mos. ds.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Rebecca Rosen

6 DATE OF BIRTH (month, day, and year) Unkown

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	41			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Builder
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Russia

PARENTS

10 NAME OF FATHER Abrahman Rosen

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Dorothy

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant Rebecca Rosen
(Address) 2801 Springdale Ave

15 Filed JUL 17 1929 19 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said inquest
(Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fractured Lung — due to Auto collision — at Pulaski & Baker Sts.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? no

7/17. 1929 (Signed) H. Braun, M. D.
(Address) 2929 McElderry

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Workman Circle Cemetary	July 17 1929

20 UNDERTAKER Jack Lewis ADDRESS 1439 E. Baltimore St

UL 17 1929

Spec.—2-29-28—L. F. S.—500 Bks.

F 47696 HEALTH DEPARTMENT—CITY OF BALTIMORE F 47696

CERTIFICATE OF DEATH

117

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., WARD)

REGISTERED NO. 13463

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Francis Perseghin

(a) RESIDENCE NO. 3803 Boarman ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 3/13/1926

7 AGE — Years: 3 Months: 4 Days: 3 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto

PARENTS

10 NAME OF FATHER: Lawrence Perseghin

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Della Bonconte

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: Julia Cristandi

(Address) 24 E. Biddle ave

15 Filed JUL 17 1929 19 C. HAMPSON JONES, M. D. Registrar

By H Kessler

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 16, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 11, 1929, to July 16, 1929, that I last saw her alive on July 16, 1929 and that death occurred, on the date stated above, at 3 25 A m.

The CAUSE OF DEATH* was as follows:

Acute appendicitis with abcess and peritonitis

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary): Intestinal obstruction

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 11, 1929

Was there an autopsy?

What test confirmed diagnosis? operation

(Signed) Louis P. Gundry, M. D.

July 16, 1929 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Stanislaus Cem

DATE OF BURIAL: July 18 1929

20 UNDERTAKER: Chas Ulrich

ADDRESS: 2008 Eutaw

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47697. HEALTH DEPARTMENT—CITY OF BALTIMORE 38 E 47697.

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 5-8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Pearl Collins

(a) RESIDENCE NO. 102 N. Eden ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 3 yrs.? mos.? ds. How long in U. S., If foreign birth? - yrs. - mos. - ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of James Collins ~~Unknown~~

6 DATE OF BIRTH (month, day, and year) 190 Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	28			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework 037

(b) General nature of industry, business, or establishment in which employed (or employer) ?

(c) Name of employer ?

9 BIRTHPLACE (city or town) (State or country) ? Virginia

PARENTS

10 NAME OF FATHER William Ennis

11 BIRTHPLACE OF FATHER (city or town) ? (State or country) Virginia

12 MAIDEN NAME OF MOTHER Ella ?

13 BIRTHPLACE OF MOTHER (city or town) ? (State or country) Virginia

14 Informant Records of

(Address) Baltimore City Hospitals

15 Filed JUL 17 1929 C. HAMPSON JONES, Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 13, 1929 to July 15, 1929 that I last saw her alive on July 15, 1929 and that death occurred, on the date stated above, at 1:00 A. m.

The CAUSE OF DEATH* was as follows:

Syphilis: Syphilis of aorta c insufficiency

Myocarditis, c Toxic

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Chronic nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Path Exam Autopsy Lab

(Signed) Marion M. McClure M. D.

7-16, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury Cem. DATE OF BURIAL 7-17 1929

UNDERTAKER Byson & Wright 1218 McElderry St ADDRESS

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 47698 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47698

CERTIFICATE OF DEATH.

104-002

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. 10-N (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John Baker

(a) RESIDENCE NO. 609 E Chase ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7/31/21

7 AGE: Years 7 8 Months 11 Days 15 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: child

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md

PARENTS

10 NAME OF FATHER Geo Baker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Carrie Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

Filed JUL 17 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1929

17 I HEREBY CERTIFY, That I attended deceased from July 12, 1929, to July 16, 1929, that I last saw h in alive on July 16, 1929, and that death occurred, on the date stated above, at 1-55 A m.

The CAUSE OF DEATH* was as follows:

Hemorrhage following T & A.

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 7/2/29

Was there an autopsy? yes

What test confirmed diagnosis?

(Signed) J. C. Goodwin, M. D.

7/16, 1929 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet

DATE OF BURIAL 7/17 1929

20 UNDERTAKER Wm Cook

ADDRESS 1217 St Paul

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47699 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47699

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 100 E 23d ST. 17-50 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Cora M. Bush

(a) RESIDENCE NO. 232 High St Weston W Va WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 8 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

6 If married, widowed, or divorced HUSBAND of (or) WIFE of Roal B. Bush

6 DATE OF BIRTH (month, day, and year) Oct 12, 1889

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	39	9	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at Home

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) Weston (State or country) West Virginia

PARENTS

10 NAME OF FATHER George H Bonnett

11 BIRTHPLACE OF FATHER (city or town) Weston (State or country) West Virginia

12 MAIDEN NAME OF MOTHER Mary C Swisher

13 BIRTHPLACE OF MOTHER (city or town) Weston (State or country) West Virginia

14 Informant Mr Roal B. Bush

(Address) 232 High St Weston W Va

15 Filed JUL 17 1929 C. HAMPSON JONES, Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16. 1929

17 I HEREBY CERTIFY, That I attended deceased from July 9, 1929, to July 16, 1929 that I last saw h alive on July 16, 1929 and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Encephalitis Lethargica

(duration) yrs. 6 mos. — ds.

CONTRIBUTORY (Secondary) Paralysis due to acute thrombosis

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? usual test & Sign & Symptom

(Signed) Harvey S Beck M. D.

July 16 1929 (Address) 100 E 23d St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Clarksburg W. Va. DATE OF BURIAL July 20 1929

20 UNDERTAKER Wm Cook ADDRESS 1217 St Paul St

important. See instructions on back of certificate.

Cor. 10-10 ... Bks.

E 47700

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47700

CERTIFICATE OF DEATH

188-92

1-PLACE OF DEATH
City of Baltimore: (No. Jno Hopkins Hosp 15-21 St., Ward)

REGISTERED NO.
(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Irvin Wilson

(a) RESIDENCE NO. 1427 N. Monut St. Ward
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 3 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: Col

5 Single, Married, Widowed or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: not married

6 DATE OF BIRTH (month, day, and year): Jan 29-1908

7 AGE: Years 21 | Months 5 | Days 14 | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer): Excavating
(c) Name of employer: O&O

9 BIRTHPLACE (city or town) ..... (State or country) Va

PARENTS

10 NAME OF FATHER: Richard Wilson

11 BIRTHPLACE OF FATHER (city or town) ..... (State or country) Va

12 MAIDEN NAME OF MOTHER: Maria Wilson

13 BIRTHPLACE OF MOTHER (city or town) ..... (State or country) Va

14 Informant: Maria Wilson
(Address) 1427 N. Monut

15 Filed JUL 17 1929 19.. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-13 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Fract Pelvis —
due to being run over by
track upon which he was
riding when it collided with
a street car Ruptured Pulmon
Accidental
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)
fracture of Femur
mos. ds.

18 Where was disease contracted if not at place of death? Bdw'y & Federal

Did an operation precede death? no Date of

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy

(Signed) H. J. Frame M. D.

7/16 1929 (Address) 2939 W. Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn

DATE OF BURIAL: 7-17 1929

UNDERTAKER: Daniel Easton

ADDRESS: Pa Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 47701

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

+ 188-VA3

Vi: 47701

1-PLACE OF DEATH

City of Baltimore: (No. City Hospitals St. 26-37 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Emily Patrick

(a) RESIDENCE NO. Back River St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 39 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Jno F. Patrick

6 DATE OF BIRTH (month, day, and year) Dont Know

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
about 48			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Work
(b) General nature of industry, business, or establishment in which employed (or employer) Domestic
(c) Name of employer

9 BIRTHPLACE (city or town) England
(State or country)

PARENTS

10 NAME OF FATHER Dont Know

11 BIRTHPLACE OF FATHER (city or town) Dont Know
(State or country)

12 MAIDEN NAME OF MOTHER Dont Know

13 BIRTHPLACE OF MOTHER (city or town) Dont Know
(State or country)

14 Informant Jno F. Patrick
(Address) Back River

15 Filed JUL 17 1929, C. HAMPSON JONES, M. D., Registrar
per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage
Struck & knocked down by auto on Eastern Ave Rd 2 days in 17 hrs in city Hosp
(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) accidental auto accident (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Eastern Ave Rd near Back River

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) J. J. Franz, M. D.

7-17 1929 (Address) 639 34th & Elder

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Carmel Cemetery — DATE OF BURIAL July 7 1929

20 UNDERTAKER George N. Zinkler — ADDRESS 1137 E. Eager

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 47702

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

89 ✓ E 47702

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 785 W. Saratoga St., 16-W Ward)

2-FULL NAME Polly Jackson

(a) RESIDENCE NO. 785 W. Saratoga St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 10 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
female	negro	Widowed

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	40			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) S. C.

PARENTS

10 NAME OF ~~FATHER~~ Alexander Black

11 BIRTHPLACE OF FATHER (city or town)
(State or country) S. C.

12 MAIDEN NAME OF MOTHER Mary Hall

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) S. C.

14 Informant Carl Sams
(Address) 785 W. Saratoga St

15 [illegible] 19 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13, 1929

17 I HEREBY CERTIFY, That I took charge of the remains deseribed above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.
The CAUSE OF DEATH* was as follows:

Angina Pectoris

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Zeller, M. D.

July 17, 1929. (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Buried in Mt Auburn Cemetery

DATE OF BURIAL July 17, 1929

20 UNDERTAKER Mrs Kate R. Williams

ADDRESS 322 N Schroeder St

JUL 17 1929 C. HAMILTON JONES, M. D.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec—12-23-21—E.B.R.S.—400 Bks.

E 47703

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47703

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

City of BALTIMORE: (No.) 935-N Saratoga St. 18-W (Ward)

Registered No.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Almira Keyser

(a) Residence No. 935-N. Saratoga St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3-SEX. F

4-COLOR OR RACE, Col

5-Single, ~~Married, Widowed, or Divorced,~~ (Write the word.) Single

5a-If married, widowed, or divorced HUSBAND of (or) WIFE of —

6-DATE OF BIRTH (month, day and year) Dec 25. 1849

7-AGE. 29 yrs. 6 mos. 20 ds. If LESS than 1 day, hrs. or min.

8-OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Domestic

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9-BIRTHPLACE (city or town) Frederick (State or Country) Md

PARENTS.

10-NAME OF FATHER, Unknown

11-BIRTHPLACE OF FATHER (city or town) Unknown (State or Country)

12-MAIDEN NAME OF MOTHER, Unknown

13-BIRTHPLACE OF MOTHER (city or town) Unknown (State or Country)

14-Informant Nellie Pearl Pantzy

(Address) 935 N Saratoga St

15-Filed JUL 17 1929

C. HAMPSON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH (month, day and year) July 15. 1929

17-I HEREBY CERTIFY, That I attended deceased from May 2, 1927 to July 14, 1929 that I last saw h. alive on July 14, 1929 and that death occurred, on the date stated above, at 6:30 a.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Antemortem

(Duration) yrs. mos. ds

CONTRIBUTORY (Secondary)

(Duration) yrs. mos. ds

18-Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys. Obs.

(Signed) E. Gale Chenault M. D.

July 17, 1929 (Address) 1534 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19-PLACE OF BURIAL, CREMATION OR REMOVAL.	DATE OF BURIAL.
Mt Auburn Cemetery	July 18, 1929
UNDERTAKER.	ADDRESS
Mrs. Kate R. Williams	3224 Edmondson Ave

In plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 47704

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74001 V E 47704

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. En route to University Hospital) St., Ward

2-FULL NAME William R. Barnes

(a) RESIDENCE NO. 634 Smith St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Negro	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Edith Barnes

6 DATE OF BIRTH (month, day, and year) March 1 - 1877

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	52	4	13	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer) O.D.
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Md

PARENTS

10 NAME OF FATHER James Barnes

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Md

12 MAIDEN NAME OF MOTHER Lottie Watts

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Md

14 Informant Mrs. Edith Barnes
(Address) 634 Smith St.

15 Filed JUL 17 1929 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 14 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Apoplexy.

(duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Eugene Feller, M. D.

7/16, 1929 (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Zion Cemetery — DATE OF BURIAL July 18, 1929

20 UNDERTAKER Mrs Katie R. Williams — ADDRESS 3224 Schroeder St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—8-24-14—M. & T.—2000 lbs.

Hartonlaris

47705

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

109-002 V

47705

1-PLACE OF DEATH 1019 E Baltimore

CITY OF BALTIMORE: (No. Presbyterian Eye Ear St. Hospital WARD)

REGISTERED NO. C

2-FULL NAME Steve Hartoularis

(Residence in Baltimore: No. 4704 Eastern Ave — St.; ..... yrs., ... mos. ..... ds.)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

PERSONAL AND STATISTICAL PARTICULARS.

3-SEX. M-

4-COLOR OR RACE, W.

5-SINGLE, MARRIED, WIDOWED, OR DIVORCED, (Write the word.)

6-DATE OF BIRTH, 1920 - May 13, 1920 (Month) (Day) (Year)

7-AGE, 9 yrs. 2 mos. 4 ds. If LESS than 1 day, ... hrs. or ..... min.?

8-OCCUPATION:
(a) Trade, profession, or particular kind of work ..... none
(b) General nature of industry, business, or establishment in which employed (or employer) .....

9-BIRTHPLACE, (State or Country), Baltimore

PARENTS.

10-NAME OF FATHER, Nick

11-BIRTHPLACE OF FATHER (State or Country), Greece

12-MAIDEN NAME OF MOTHER Leonis

13-BIRTHPLACE OF MOTHER (State or Country), Greece

14-THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Informant) Mrs Hartoularis.

(Address) 4704 Eastern Ave E.

15- Filed July 17 1929 H. [illegible] JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH.

16-DATE OF DEATH, July (Month) 17, (Day) 1929 (Year)

17- I HEREBY CERTIFY, That I attended deceased from July 16 1929, to July 17 1929, that I saw him alive on July 17 1929, and that death occurred, on the date stated above, at ..... m.

The CAUSE OF DEATH* was as follows:

Myocarditis - Tuberculosis

(Duration) ..... yrs. ..... mos. 1 ds.

CONTRIBUTORY (Secondary) Tuberculosis

(Duration) ..... yrs. ..... mos. ..... ds.

(Signed) Birkhead MacGowan M. D.

July 17, 1929 (Address) Med Dr to Hdq

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18-LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS).

At place of death 0 yrs. 0 mos. 1 ds. In the State ..... yrs. ..... mos. ..... ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19-PLACE OF BURIAL OR REMOVAL, Woodlawn Cemetery DATE OF BURIAL, July 19 1929

20-UNDERTAKER Mary M. Warfield ADDRESS 50 E Lex St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement of DESCRIPTION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

C 47706 — 47706

CERTIFICATE OF DEATH

1-PLACE OF DEATH Church Home & Infirmary

CITY OF BALTIMORE: (No.) Fairmont & Eutaw (Ward) 69

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Green Todd

(a) RESIDENCE NO. Belair Md ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? yrs. mos. 1 ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Sarah Cheek Todd

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
75	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Belair Md.

PARENTS

10 NAME OF FATHER: Arnet Todd

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant (Address): Roscoe Todd Belair Md

15 Filed JUL 17 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7/17 1929

17 I HEREBY CERTIFY, That I attended deceased from 7/17, 1929, to 7/17, 1929, that I last saw him alive on 7/17, 1929, and that death occurred, on the date stated above, at 2:20 P. m.

The CAUSE OF DEATH* was as follows:

Mesenteric Thrombosis
Gangrene of Intestines

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 7/17/29

Was there an autopsy? No

What test confirmed diagnosis? Clinical & Operation

(Signed) Orin B. Wallace M. D.

, 19 (Address) Church Home & Infirmary

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Zion Hartsdale — DATE OF BURIAL: July 19 29

20 UNDERTAKER: Deaver & Foster Belair Md — ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT OF DISEASE OR CONDITION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47707 — 129 — E 47707

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4412 Roland Ave ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Kate France Thompson

(a) RESIDENCE NO. 4412 Roland Ave ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. 0 mos. 0 ds. How long in U. S., if foreign birth? 77 yrs. 2 mos. 9 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widow

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Albert E. Thompson

6 DATE OF BIRTH (month, day, and year) May 7 1852

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	77	2	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer) none

(c) Name of employer none

9 BIRTHPLACE (city or town) (State or country) Washington D. C.

PARENTS

10 NAME OF FATHER John France

11 BIRTHPLACE OF FATHER (city or town) (State or country) England

12 MAIDEN NAME OF MOTHER Maria Pratt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) England

14 Informant Mr. Albert E Thompson

(Address) 4412 Roland Ave

15 Filed ... 19... C. HAMPSON JONES, M. D. Registrar

17 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1929

17 I HEREBY CERTIFY, That I attended deceased from June 9 1929 to July 16 1929

that I last saw h[illegible] alive on July 15 1929

and that death occurred, on the date stated above, at 9 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) Chronic Bright's Disease arteriosclerosis (duration) 4 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy? —

What test confirmed diagnosis? Clinical findings

(Signed) W. Hilbert Ford M. D.

1929 (Address) 20 E. Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cemetery	July 18 1929
20 UNDERTAKER	ADDRESS
Thomas Watson & Co	Balto

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47708

CERTIFICATE OF DEATH

71-001

E 47708

1—PLACE OF DEATH

CITY OF BALTIMORE; (No. St Josephs Hospital ST., 8-17 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Ethel M Schatz

(a) RESIDENCE NO. 1636 N Wolfe St ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 17 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry L Schatz

6 DATE OF BIRTH (month, day, and year) 4/18/1898

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
31	2	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) Own

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Thomas L Wilt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md.

12 MAIDEN NAME OF MOTHER Amanda Gilbrone

12 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Henry L Schatz

(Address) 1636 N Wolfe St

15 Filed JUL 17 1929, 19 HAMBLETON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17-1929

17 I HEREBY CERTIFY, That I attended deceased from July 15, 1929, to July 16, 1929, that I last saw h[illegible] alive on July 17, 1929, and that death occurred, on the date stated above, at 2.05 A. m.

The CAUSE OF DEATH* was as follows:

Meningitis - from posterior dysfunction - streptococci.

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary) Pulmonary congestion

(duration) yrs. mos. ½ ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? ~~xxx~~ Date of April

Was there an autopsy? Yes.

What test confirmed diagnosis? Bacteriological

(Signed) S. Robert Dardo, M. D.

, 19 (Address) 3105 Belair Road.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	7/20 1929
20 UNDERTAKER Albert L Nitz	ADDRESS 1604 N Chester St

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 47709 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47709

CERTIFICATE OF DEATH. 129

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1318 N. Fawall St. 1623 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Bertha Craig.

(a) RESIDENCE NO. 1318 N. Fawall ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 11 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE Colored

5 Single, Married, Widowed, or Divorced, (write the word) married,

5a If married, widowed, or divorced HUSBAND of (or) WIFE of John craig,

6 DATE OF BIRTH (month, day, and year) Apr 16 1891

7 AGE Years 38 Months 3 Days / If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 037

(b) General nature of industry, business, or establishment in which employed (or employer) at home

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Prince George Co Md

PARENTS

10 NAME OF FATHER Thomas Countee

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant (Address) John craig 1318 N Fawall St

15 Filed JUL 18 1929 C. HAMPSON JONES, M. D. Registrar

L 18 1929 Pat Giles

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1929

I HEREBY CERTIFY, That I attended deceased from July 2 1929, to July 15th 1929, that I last saw her alive on July 15 1929, and that death occurred, on the date stated above, at 4.30 A. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous nephritis

CONTRIBUTORY (Secondary) Pt Causation (duration) yrs. 3 mos ds.

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Leo. H. Kayserbach M. D.

7-16-1929 (Address) 2215 N. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Crown's Prince georg Co Md

DATE OF BURIAL July 18 1929

20 UNDERTAKER Thomas E. Kelson

ADDRESS 1303 Presstman St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—7-17-26—A Co.—200 Bks.

47710

HEALTH DEPARTMENT—CITY OF BALTIMORE

100-001 47710

CERTIFICATE OF DEATH

1-PLACE OF DEATH Jenkins Memorial Hospital REGISTERED NO.

City of BALTIMORE: (No. 1000 Eaton Ave St., 8-17 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Matilda Wood

(a) RESIDENCE NO. 1744 East North Ave St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. (If non-resident give city or town and State) How long in U. S. if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 27 - 1859

7 AGE — Years: 70 Months: 1 Days: 18

IF LESS than 1 day ..... hrs. or ..... min..

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md.

PARENTS

10 NAME OF FATHER Welkney

11 BIRTHPLACE OF FATHER (City or town) Balt Md

(State or country)

12 MAIDEN NAME OF MOTHER Killian

13 BIRTHPLACE OF MOTHER (city or town) Balt Md

(State or country)

14 Informant Jenkins Memorial Hospital

(Address)

15 Filed JUL 18 1929 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15 1929

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1929, to July 15, 1929, that I last saw her alive on July 15, 1929, and that death occurred, on the date stated above, at 10: P. m.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Nicholas Pontelli, M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Woodlawn — Date of Burial: July 18 1929

20 UNDERTAKER: Franklin H Seitz — ADDRESS: 709 W 33 St.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

Dr. Howard D Bullert 821 medical arts bldg

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47711

CERTIFICATE OF DEATH

129 E 47711

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1511 E Chase St. 13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna Bruckner

(a) RESIDENCE NO. 1511 E. Chase ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov 8-1888

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
40	41	— 8	— 7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Louis C. Wurst

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Anna M. Wurst

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14

Informant Leonard Wurst

(Address) 1511 E Chase St

15

Filed July 18, 1929

C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15, 1929

17

I HEREBY CERTIFY, That I attended deceased from May 13, 1929, to July 15, 1929

that I last saw her alive on July 15, 1929

and that death occurred, on the date stated above, at 6 30 P m.

The CAUSE OF DEATH* was as follows:

Cardio vascular renal Disease

(duration) 3 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Howard D Bullert, M. D.

July 17, 1929 (Address) 821 Medical Arts Bldg

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Western Cem

DATE OF BURIAL 7-18 1929

20 UNDERTAKER Daniel Easter

ADDRESS 916 Eutaw

Important. See instructions on back of certificates.

18 1929

Cor.—10-10-29—A Co.—100 Bks.

E 47712

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47712

REGISTERED NO. 198

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Franklin Square St. Hosp. Ward)

2-FULL NAME Richard Wilson

(a) RESIDENCE NO. 1704 Monroe St., 20 Ward

(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1905

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
	24	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Va.

PARENTS

10 NAME OF FATHER Henry Wilson

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Va

12 MAIDEN NAME OF MOTHER Anna Boland

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Va.

14 Informant Henry Wilson
(Address) 1704 Monroe St

15 Filed ..... 19 C. HAMPSON JONES, M. D. Registrar
Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 13 1929

17 I HEREBY CERTIFY that I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to h death on the day stated above.

The CAUSE OF DEATH* was as follows:

Internal Hemorrhage from Stab wound through Liver and Lungs

..... (duration) ..... yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) (0 ew)

..... (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Thurston Brooks M. D.

July 16 1929 (Address) 3601 Gordon Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	7-18 1929
20 UNDERTAKER	ADDRESS
Dennis Easton	9 N Gay

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN'S should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JUL 18 1929

Spec.—2-29-28—L. F. S.—500 Bks.

E 47713 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47713

100-001

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1723 Riggs Av St., 16-2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Eugene Catlett, Jr

(a) RESIDENCE NO. 1723 Riggs Av ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 6, 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
			10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work none

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country) Md

PARENTS

10 NAME OF FATHER Eugene Catlett Sr

11 BIRTHPLACE OF FATHER (city or town) Pa
(State or country)

12 MAIDEN NAME OF MOTHER Anna Christian

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country) Md

14 Informant Father

(Address) 1723 Riggs Av

15 Filed 1929, C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/16/29

17 I HEREBY CERTIFY, That I attended deceased from 7/15, 1929, to 7/16, 1929

that I last saw h alive on 7/16, 1929

and that death occurred, on the date stated above, at 11.30 P. m.

The CAUSE OF DEATH* was as follows:

Broncho-Pneumonia
(Primary)

(duration) yrs. mos. 3 ds.

CONTRIBUTORY
(Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

7/17/29 (Address) 912 Eutaw St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	7-18 1929

20 UNDERTAKER David Carter ADDRESS 916 Pa Ave

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 47714

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001 E 47714

1-PLACE OF DEATH

City of Baltimore: (No. 227 W. Hill St. 22-31 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Needy Anderson.(C)

(a) RESIDENCE NO. 227 W. Hill St. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 12 yrs. ~~mos.~~ ~~ds.~~ How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Colored	Married.

5a If married, ~~widowed or divorced~~ HUSBAND of ~~XXXXXXXXXX~~ Sally Anderson.(C)

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	59	---	---	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Virginia.
(State or country)

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Sally Anderson.(C) wife.
(Address) 227 W. Hill St.

15 Filed ....., 19.....

JUL 18 1929

C. HAMPSON JONES, M. D.
Registrar

By [illegible]

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Cerebral Apoplexy.

(duration) yrs. mos. ds.

CONTRIBITORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Steinhardt, M. D.

7/17 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Calvary Cemty

DATE OF BURIAL 7/18 1929

20 UNDERTAKER Walter B. Spriggs

ADDRESS 139 W. Hamburg St.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47715

CERTIFICATE OF DEATH.

118-001 E 47715

1-PLACE OF DEATH St Agnes Hospital

CITY OF BALTIMORE: (No. Caton & Wilkens Ave ST.) 15-67 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs Kate Mondscheir

(a) RESIDENCE No. 1713 Rosedale ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 9 yrs. mos. ds. How long in U. S., if of foreign birth? 9 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female

4 COLOR OR RACE white

5 Single, Married, Widowed, or Divorced, (write the word) married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of William Mondscheir

6 DATE OF BIRTH (month, day, and year) deceased

7 AGE Years 58 Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Nume of employer

9 BIRTHPLACE (city or town) (State or country) Hungary

PARENTS

10 NAME OF FATHER Zalman Krause

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Regis Monshine

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant William Mondscheir

(Address) 1713 Rosedale St

Filed JUL 18 1929

C. HAMPSON JONES, M. D. Registrar

Per ES

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-17 1929

17 I HEREBY CERTIFY, That I attended deceased from 7-15, 1929, to 7-17, 1929, that I last saw h[illegible] alive on 7-17, 1929, and that death occurred, on the date stated above, at 7.35 p m.

The CAUSE OF DEATH* was as follows:

Myocardial failure

Edema of Lungs

(duration) yrs. mos 2 ds.

CONTRIBUTORY (Secondary) Operation, Hernia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 7-16 29

Was there an autopsy? yes

What test confirmed diagnosis? Physical

(Signed) Jacob L. Bouell M. D.

, 19 (Address) St Agnes Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Nursing Home

DATE OF BURIAL 7-18-1929

20 UNDERTAKER Jack Lewis

ADDRESS 1439 E Balto

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47716

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

40 E 47716

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1837 E Layfayette ave (WARD) 6-9

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME J. Hamilton J. Jenkins

(a) RESIDENCE NO. 1837 E. Layfayette ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 4 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 ~~Single, Married~~, Widowed, ~~or Divorced~~ (write the word): Widower

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Ella R. Jenkins

6 DATE OF BIRTH (month, day, and year): March 16 1854

7 AGE: Years 75 | Months 4 | Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired Clerk.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Joseph Jenkins

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Ella R. Hattenbury

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Warren Jenkins

(Address) 230 Cliftwood ave

15 Filed JUL 18 1929 C. HAMPSON JONES, D.

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 16 1929.

17 I HEREBY CERTIFY, That I attended deceased from Jan 28 1929. to July 16 1929. that I last saw h alive on. July 10 1929 and that death occurred, on the date stated above, at 5.30 a. m.,

The CAUSE OF DEATH* was as follows:

Arteriosclerosis - Nephritis

Chronic for many years.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? —

What test confirmed diagnosis? —

(Signed) Irving Miller, M. D.

July 16 1929 (Address) 108 E. North ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery

DATE OF BURIAL: July 19 1929

20 UNDERTAKER

ADDRESS: Geo. L. Ruth 1735 Harford ave

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 47717

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47717

CERTIFICATE OF DEATH

1-PLACE OF DEATH Pronounced dead at the

City of Baltimore: (No. Mercy Hospital. St. 10-14 Ward)

REGISTERED NO. 90

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME William Young.

(a) RESIDENCE NO. 1002 E. Chase St. St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 67 yrs. ---- mos. ---- ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married.

5a If married, HUSBAND of (WIFE of) Martha Young.

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
	67	----------		

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Watchman.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore. Md.
(State or country)

PARENTS

10 NAME OF FATHER Aloysius Young.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do not know.

14 Informant Martha Young. (wife)
(Address) 1002 E. Chase St.

15 Filed JUL 18 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Endocarditis.

Acute dilatation of the Heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? In front of 218 N. Gays. July 15, 1929

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M. Leinhardt, M. D.

7/17 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL. St. Lincoln Cemetery DATE OF BURIAL July 19 1929

20 UNDERTAKER Penny Hoeck Bros. Inc. ADDRESS 1301 E. Eager St.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should give CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

E 47718

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47718

CERTIFICATE OF DEATH.

16-001

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital St. 4-36 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Baby boy Reechel.

(a) RESIDENCE NO. Millersville, Md St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year) July 10, 1929

7 AGE Years	Months	Days	If LESS than 1 day 11 hrs or min.
New born infant			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Otto Frederick Reechel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Iva Leona Humphrey

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Millersville, Md.

14 Informant Mrs. Iva Leona Reechel

(Address) Millersville, Md.

15 Filed JUL 18 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 10 1929

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1929, to July 10, 1929, that I last saw him alive on July 10, 1929, and that death occurred, on the date stated above, at 4:20 P. m.

The CAUSE OF DEATH* was as follows:

Congenital Atelectasis

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary) Prematurity 3/4 hrs

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Physical signs.

(Signed) Louis A Kopelman, M. D.

(Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL

DATE OF BURIAL 19

20 UNDERTAKER

ADDRESS

UNIVERSITY OF MARYLAND

HAMPTON JONES, M. D.

Commissioner Health

JUL 16 1929

CAUSE OF DEATH in plain terms, so that it may be properly TION is very important. See instructions on back of certificates.

ST. WM. & WOOD

Spec. 12-23

E 47719

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47719

CERTIFICATE OF DEATH.

31

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1414 (St.) Madison Ave (WARD) 20

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Alfred Perkins

(a) RESIDENCE NO. 1414 (St.) Madison Ave WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 15, 1886

7 AGE: Years 43 Months 0 Days 1 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Janitor 070

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Sarah E Perkins

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Maryland

14 Informant: Lucy Perkins

(Address) 1414 Madison Ave

Filed JUL 18 1929 C. THAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 16 1929

17 I HEREBY CERTIFY, that I attended deceased from July 14 1929 to July 16 1929 that I last saw h alive on July 15 1929 and that death occurred, on the date stated above, at 5.25 m.

The CAUSE OF DEATH* was as follows:

Pleurisy Pulmonalis

(duration) yrs. 6 mos — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) W. D. Howells, M. D.

(Address) 1921 Carrollton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem DATE OF BURIAL: July 18 1929

UNDERTAKER: Samuel Hensley ADDRESS: 578 N Broadway

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47720

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

100-001 ✓

E 47720

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 528 N Mont ST. 19-27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie Gross

(a) RESIDENCE NO. 528 N. Mont ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 5 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Feb 9 1929

7 AGE — Years | Months: 5 | Days: 9 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: none

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: James Gross

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Addie Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14

Informant: Addie Gross

(Address) 528 N Mont

15

Filed JUL 18 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 17-1929

17

I HEREBY CERTIFY, That I attended deceased from July 15, 1929, to July 17, 1929, that I last saw her alive on July 16, 1929 and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) [illegible], M. D.

July 18, 1929 (Address) 7 Franklin Sq

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Auburn Cem — DATE OF BURIAL: 7/18 1929

20 UNDERTAKER: Daniel Easton — ADDRESS: No 2 Cor

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47721

HEALTH DEPARTMENT—CITY OF BALTIMORE

161-005

E 47721

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Mercy Hospital ST. 15-51 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Baby Girl Rankin

(a) RESIDENCE NO. 322 or Pulaski ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 7/17/29

7 AGE	Years	Months	Days	If LESS than 1 day, ~~2~~ hrs. or ~~7~~ min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Mercy Hospital
(State or country) Maryland

PARENTS

10 NAME OF FATHER Albert I Rankin

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Sophia Friedman

13 BIRTHPLACE OF MOTHER (city or town) Russia
(State or country)

14 Informant Hosp. Records
(Address)

15 Filed JUL 18 1929 19 C. HARRISON JONES, M. D.
Registrar
By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/17/29

17 I HEREBY CERTIFY, That I attended deceased from 7/17, 1929, to 7/17, 1929,
that I last saw h~~e~~r alive on 7/17/29, 1929
and that death occurred, on the date stated above, at 10:15 P m.

The CAUSE OF DEATH* was as follows:

Asphyxia Neonatorum

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Congenital weakness

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) David Feiner, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Friendship	7-18- 1929
20 UNDERTAKER	ADDRESS
Jack Levis	1429 E Balto

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47722

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47722 ✓

31

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1715 Covington St. 24-34 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Margaret B. Dowlin

(a) RESIDENCE NO. 1715 Covington ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 61 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

6 If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 13 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	61	3	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired Teacher

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md.

PARENTS

10 NAME OF FATHER William Dowlin

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Elizabeth Gallaway

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Mr. Dowlin

(Address) 1715 Covington St.

15 Filed JUL 18 1929 C. HARRISON JONES, M. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-18-1929

17 I HEREBY CERTIFY, That I attended deceased from July 11, 1929, to July 18, 1929, that I last saw h er alive on July 18, 1929, and that death occurred, on the date stated above, at 2-25 A. M.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) ? yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Physical signs

(Signed) Sidney H. Streett M. D.

7/18 1929 (Address) 1445 E. East Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park Cemetery

DATE OF BURIAL 7/20 1929

20 UNDERTAKER D. J. Fenwick & Bro

ADDRESS 130 E Fort

Important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 47723

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 47723

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 925 N. Eden ST.) (WARD) 10-13

2-FULL NAME Susan Jones Stokes

(a) RESIDENCE No. 925 N. Eden ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colord	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1883

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	46			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER Alex Rogers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Hattie Brown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Minnie Henry

(Address) 502 N. Stricker St.

15 Filed JUL 18 1929 19 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15, 19 29

17

I HEREBY CERTIFY, That I attended deceased from March, 19 29, to July 15, 19 29,

that I last saw her alive on July 15, 19 29,

and that death occurred, on the date stated above, at 8:05 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 5 mos ds.

CONTRIBUTORY (Secondary) Nephritis (Acute)

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. H. Tuttle, M. D.

19 (Address) 1029 Madison Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Woodlawn cemetery

DATE OF BURIAL July 18 1929

20 UNDERTAKER Edward Bryan

ADDRESS 1631 Orleans st

mation should be carefully supplied. Also mean the words CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 47724

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

153

E 47724

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bon Secours Hospital ST. 1928 (WARD)

2-FULL NAME Margaret Mary England

(a) RESIDENCE NO. 2121 W. Baltimore ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F

4 COLOR OR RACE: W

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 12 1914

7 AGE: Years 15; Months; Days 5; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: School

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Maryland

PARENTS

10 NAME OF FATHER: John L. Englund

11 BIRTHPLACE OF FATHER (city or town) (State or country): Sweden

12 MAIDEN NAME OF MOTHER: Cecelia Collins

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Sweden

14 Informant: J. D. Keating

(Address) 2122 W. Baltimore St

15 Filed OCT 18 1929, 19 C. HAMPSON JONES, M. D., Registrar

BY

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/17 1929

17 I HEREBY CERTIFY, That I attended deceased from 7/13/29, to 7/17, 19 29.

that I last saw h alive on 7/17, 19 29,

and that death occurred, on the date stated above, at 12 50 p m.

The CAUSE OF DEATH* was as follows:

Staphylococcus septicemia

Multiple abscesses

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary): Abrasion on heel

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 7/15/29

Was there an autopsy? No

What test confirmed diagnosis? Lab.

(Signed) Theo Estacy, Jr. M. D.

, 19 (Address) Bon Secours Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cathedral Cem

DATE OF BURIAL: 7/20/29

20 UNDERTAKER: Geo. A. Kemp Funeral Chapel

ADDRESS

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

E 47725

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47725

CERTIFICATE OF DEATH.

38

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Franklin Sq. Hosp. (ST.) 69 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Frank Maloney

(a) RESIDENCE NO. 67 Gorman Ave ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of or) WIFE of: Ellen Maloney

6 DATE OF BIRTH (month, day, and year): Aug 6. 1890

7 AGE

Years	Months	Days	If LESS than 1 day, hrs or min.
38	11	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md.

PARENTS

10 NAME OF FATHER: Thos E. Maloney

11 BIRTHPLACE OF FATHER (city or town) (State or country): England.

12 MAIDEN NAME OF MOTHER: Emma J Banahan.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: Ellen Maloney (Address) 67 Gorman Ave.

15 Filed JUL 18 1929 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 16 1929

17 I HEREBY CERTIFY, That I attended deceased from July 13, 1929, to July 16, 1929, that I last saw h[illegible] alive on July 16, 1929, and that death occurred, on the date stated above, at 10 15 A m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. mos ds.

CONTRIBUTORY (Secondary): Syphilis of nervous system

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical picture

(Signed) Arthur Kallenus, M. D.

, 19 (Address) Franklin Sq. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: New Cathedral — DATE OF BURIAL: July 20 29.

20 UNDERTAKER: Geo. Fraley — ADDRESS: 1800 N. Fayette St

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47726

CERTIFICATE OF DEATH

E 47726

1-PLACE OF DEATH

City of Baltimore: (No. South Balto General Hosp St., Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Doris F. Feeley

(a) RESIDENCE NO. 112 E Barney St., Ward

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced. (Write the word)
F	W	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) July 14-1920

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	8	11	27	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Student
(b) General nature of industry, business, or establishment in which employed (or employer) School
(c) Name of employer

9 BIRTHPLACE (city or town) Balto md
(State or country)

PARENTS

10 NAME OF FATHER Michael J Feeley

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Christina Kelm

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Balto

14 Informant Michael J Feeley
(Address) 112 E Barney

Filed JUL 18 1929 G. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Rupture of Intestines -
Run over by auto in 1700 Block Light St -

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Peritoneal Hemorrhage

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? in 1700 Block Light St

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? no

(Signed) D. Crane, M. D.

7/17 1929 (Address) 2936 Mc Elder

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Cross Cemetery	July 19 1929
20 UNDERTAKER Margaret E Flynn	ADDRESS 14 W Preston

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS signing STATE CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47727.

CERTIFICATE OF DEATH

118-001

REGISTERED NO. E 47727.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (No. ST. 6-10 WARD)

2—FULL NAME Mary A. McKinley

(a) RESIDENCE NO. 416 N Collington Ave ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Thomas McKinley

6 DATE OF BIRTH (month, day, and year): June 25th 1880

7 AGE — Years: 49 | Months: 0 | Days: 20 | If LESS than 1 day, ... hrs. or .... min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House-work

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Wm. Buckley

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va.

12 MAIDEN NAME OF MOTHER: Ann Morley

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va.

14 Informant: Thomas McKinley

(Address) 416 N. Collington Ave.

15 Filed JUL 16 1929, 19.... HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7-16-29

17 I HEREBY CERTIFY, That I attended deceased from 7-4, 1929, to 7-16, 1929

that I last saw her alive on 7-16, 1929

and that death occurred, on the date stated above, at 12.35 A m.

The CAUSE OF DEATH* was as follows:

Strangulated ventral hernia

(duration) .... yrs. .... mos. 11 ds.

CONTRIBUTORY (Secondary): Toxic Myocarditis

(duration) .... yrs. .... mos. 9 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of 7-4-29

Was there an autopsy? No

What test confirmed diagnosis? Clinical symptoms

(Signed) J Yagho, M. D.

7/16 1929 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Cross Cemetery (Hartsdale) — DATE OF BURIAL: 7/19/1929

20 UNDERTAKER: E. J. Fanning & Son - 1938 — ADDRESS: E. Lafayette Ave

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47728

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47728

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) South Baltimore General Hospital (ST. OR WARD)

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Andrew J. Henningsen

(a) RESIDENCE NO. 1137 Hamburg St WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 36 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Mata Henningsen

6 DATE OF BIRTH (month, day, and year): Oct 30 1851

7 AGE: Years 77 | Months 8 | Days 17 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer): Groceryman

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Denmark

PARENTS

10 NAME OF FATHER: Jacob Henningsen

11 BIRTHPLACE OF FATHER (city or town) (State or country): Denmark

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: August J. Henningsen

(Address) 1117 Gr. Hamburg St

15 Filed 1929 or [illegible] C. HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7-18-29

17 I HEREBY CERTIFY, That I attended deceased from 7-16, 1929, to 7-18, 1929

that I last saw h[illegible] alive on 7-18, 1929

and that death occurred, on the date stated above, at 3.45 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Oedema

Cerebral Oedema

(duration) yrs. mos. 3 ds.

CONTRIBUTORY (Secondary) Cardio-Vascular Renal Disease (duration) yrs. 6 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Joseph G. Laukaitis, M. D.

(address) South Baltimore General Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Olivet — DATE OF BURIAL: July 20, 1929

20 UNDERTAKER: Mr. & Mrs. John W. Teufel & Son — ADDRESS: 801 W. Fayette

important. See instructions on back of certificates.

Spec.—I-10-21—M&T—1500 Bks.

47729

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

44 E 47729

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Franklin Sq. Hosp. (St.) 9-18 (Ward)

2-FULL NAME Oliver Christopher

(a) RESIDENCE No. 2012 Kennedy ave. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Pearce

6 DATE OF BIRTH (month, day, and year) Feb 6 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or ..... min.
	69	5	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Sexton

(b) General nature of industry, business, or establishment in which employed (or employer) Fulton Ave Baptist Church

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Oliver Christopher

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Mabelle Christopher

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Elmer Christopher (Address) 2012 Kennedy Ave

15 Filed JUL 18 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 1929.

17 I HEREBY CERTIFY, That I attended deceased from July 13, 1929, to July 17, 1929, that I last saw him alive on July 17, 1929, and that death occurred, on the date stated above, at 9.40 A m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach and Liver

(duration) yrs. ¾ mos ds.

CONTRIBUTORY (Secondary) –

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? –

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical symptoms

(Signed) Arthur Rattenni, M.D.

7/18 1929 (Address) Franklin Sq. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Loudon Park — DATE OF BURIAL July 20 1929

20 UNDERTAKER E B Kippert — ADDRESS 1500 N Bacs St

L 18 1929

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47730 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47730

CERTIFICATE OF DEATH

101-001

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1614 E. Eager St ST. 7-13 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Marie Hajek

(a) RESIDENCE NO. 1614 E. Eager St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Emanuel Hajek

6 DATE OF BIRTH (month, day, and year) Don't Know

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
90	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Bohemia

PARENTS

10 NAME OF FATHER Chas Banesch

11 BIRTHPLACE OF FATHER (city or town) (State or country) Bohemia

12 MAIDEN NAME OF MOTHER Sarah Herman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Bohemia

14 Informant Ignatz Banesch

(Address) 1001 E. Biddle St

Filed JUL 19 1929 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-17-29

17 I HEREBY CERTIFY, That I attended deceased from 7-17-29, to 7-17-29, that I last saw h alive on 7-17-29 and that death occurred, on the date stated above, at 8 A.M. m.

The CAUSE OF DEATH* was as follows: Coron Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Acute Cardiac Dilatation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Findings

(Signed) H. Neil Bernstein M. D.

7-18 19 (Address) 800 N. Wolfe St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Greenmount Cemetery

20 UNDERTAKER Ehrens & Co

DATE OF BURIAL July 19 1929

ADDRESS 1432 Hustenstown Rd.

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 47731

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47731

CERTIFICATE OF DEATH

25-12 188-20

1-PLACE OF DEATH

City of Baltimore: (No. St. Agnes Hospital St. Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Mary Spector

(a) RESIDENCE NO. 449 G St N.W. Washington D.C. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U. S., if of foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female | 4 Color or Race: White | 5 Single, Married, Widowed or Divorced, (write the word): Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Isreal Spector

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	65	—	—	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Housework
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Russia

PARENTS

10 NAME OF FATHER Louis Sterberg

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Russia

14 Informant: Jack Lewis
(Address) 1439 E. Balto St.

15 Filed JUL 19 1929 C. HAMPSON JONES, M. D. Registrar

Per

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/19 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.)

thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Fract Hip, Double fract skull the result of fall in which she was ridg or returning on wash board (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis (duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Wash Rd & Dorsey

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) L. Krame M. D.

7/19 1929 (Address) 2939 W Eager

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Humicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Hebrew Mt Carmel	July 19 1929
20 UNDERTAKER	ADDRESS
Jack Lewis	1439 E Balt

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make a DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47732

NANSE

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47732

CERTIFICATE OF DEATH

114

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1426 McElderry ST. 5 9 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Reba Carr Nanse

(a) RESIDENCE NO. 1426 McElderry ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	C	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 15 1902

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26	10	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Cambridge Md

PARENTS

10 NAME OF FATHER Lemuel Carr

11 BIRTHPLACE OF FATHER (city or town) (State or country) Del.

12 MAIDEN NAME OF MOTHER Kelly Watson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Lemuel Carr (Father)

(Address) 711 Canal St.

15 Filed JUL 19 1929 C. HAMPSON JONES, M. D.

By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18 1929

17 I HEREBY CERTIFY, That I attended deceased from April, 1929, to July 18, 1929, that I last saw h W alive on July 17, 1929 and that death occurred, on the date stated above, at 1 30 A.M.

The CAUSE OF DEATH* was as follows:

Ulcer Intestines & Hemmorhage

Recurring (duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary) Intestinal Hemmorhage.

(duration) yrs 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical

(Signed) R F Young, M. D.

7/18, 1929 (Address) 1424 E Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem. DATE OF BURIAL: July 21 1929

20 UNDERTAKER: Chas. H. Johnson ADDRESS: 446 N. Carolina St.

Important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 47733

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47733

CERTIFICATE OF DEATH

X 18

1-PLACE OF DEATH

City of Baltimore: (No. South Baltimore General Hospital St., 24-33 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Alfred Frietag.

(a) RESIDENCE NO. Lot 22 Old Annapolis Rd. St., North Linthicums. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ----------

6 DATE OF BIRTH (month, day, and year) December 2, 1928

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	0	7	15	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore, Md.
(State or country)

PARENTS

Adopted.
10 NAME OF FATHER Frank J. Frietag

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER
Adopted. Ethel May Brannan

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore, Md.

14 Informant Ethel M. Frietag. (adopted mother)
(Address) North Linthicum.

15 Filed JUL 19 1929 E. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17, 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Concussion of the Brain.
Accidental fall down steps.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at his residence July 14, 1929

Did an operation precede death? Yes. Date of July 15, 1929

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto Reinhardt M. D.

7/18, 1929 (Address) 917 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Lem A. Abs DATE OF BURIAL July 19th 1929

20 UNDERTAKER L & B. Harle ADDRESS 115 E. Montgomery

tion should be carefully supplied. AGE should be stated EXACTLY. FIGURES should be used. OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—1 S S—500 Bks.

E 47734

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47734

CERTIFICATE OF DEATH

46

1—PLACE OF DEATH

CITY OF BALTIMORE, (No. 521 Bloom ST., 4-20 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rachel M Ridgway

(a) RESIDENCE NO. 521 Bloom ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Widow

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1874

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or....min.
	55			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Albert Ridgway

(Address) 413 Carrollton Ave

15 Filed JUL 19 1929. C. HAMPSON JONES, M. D., Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16 29

17 I HEREBY CERTIFY, That I attended deceased from Dec. 3. 28, 19.., to July 15, 19 29

that I last saw h alive on July 15, 19 29

and that death occurred, on the date stated above, at 11-45 AM m.

The CAUSE OF DEATH* was as follows:

Carcinoma Uteri

Exhaustion (duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) S. B. Jugley M. D.

July 19 19 29 (Address) 1412 E. Fall Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	July 19 1929.

20 UNDERTAKER Samuel T Hensley

ADDRESS 578 N Bridge St

important. See instructions on back of certificates.

Spec.—2-29-28—J. F. S.—500 Blks.

E 47735

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47735

CERTIFICATE OF DEATH

31

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 3914 Frisby ST.) 9-47 WARD)

2—FULL NAME Ella Lee Biddison

(a) RESIDENCE NO. 3914 Frisby ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 59 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widowed

If married, widowed, or divorced HUSBAND of (or) WIFE of: Geo. E. Biddison

6 DATE OF BIRTH (month, day, and year): Feb. 29/1870

7 AGE: Years 59 | Months 4 | Days 18 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Balto Md.

PARENTS

10 NAME OF FATHER: Wm Warfield

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md.

12 MAIDEN NAME OF MOTHER: Sarah Brushwood

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Va

14 Informant: Mrs. Robert Cross

(Address) 3914 Frisby St.

15 Filed JUL 19 1929

C. HAMPSON JONES, M.D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 18/29

17 I HEREBY CERTIFY, That I attended deceased from Sept. 1927 to July 18 1929

that I last saw h alive on July 17 1929

and that death occurred, on the date stated above, at 4:45 P.M.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 7 yrs. — mos. — ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? at plan (illegible)

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) John F. Finby, M. D.

7/18, 1929 (Address) 4 E. Preston St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: W. Ft. Olivet Cem

DATE OF BURIAL: July 20 1929

20 UNDERTAKER: Charles Henrig

ADDRESS: 2016 Eden St

important. See instructions on back of certificates.

Spec.—1500 Blks.

E 47736

22711 8

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47736

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) JOHNS HOPKINS HOSPITAL ST. 2425 WARD 12

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Robert Clark

(a) RESIDENCE No. 1336 Arden St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 6 mos. 12 ds. How long in U. S., If of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 1/5/29

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	—	6	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer) 0

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md —

PARENTS

10 NAME OF FATHER Robert Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md —

12 MAIDEN NAME OF MOTHER Mami Jonske

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md —

14 Informant Records —

(Address) JOHNS HOPKINS HOSPITAL

Filed JUL 19 1929 C. HAMPSON JONES, M. D.

Per Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 1929

17 I HEREBY CERTIFY, That I attended deceased from July 11. 1929. to July 17. 1929. that I last saw him alive on July 17. 1929. and that death occurred, on the date stated above at 12 30 m.

The CAUSE OF DEATH* was as follows:

Entero colitis

(duration) yrs. mos 11 ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Phys exam

(Signed) J. C. Goodwin M. D.

7/17 1929 (Address) J. H. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cemetery DATE OF BURIAL July 19 1929

UNDERTAKER George L. Schnabel ADDRESS 2101 Fark Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 47737

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47737

CERTIFICATE OF DEATH

1929

1-PLACE OF DEATH

City of Baltimore: (No. Provident Hosp. St. 13-54 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Walter Gray

(a) RESIDENCE NO. 2448 Frances St.. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 48 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Married

6 DATE OF BIRTH (month, day and yr.) Apr 22-1881

7 AGE	Years	Months	Days	IF LESS than 1 day ... hrs. or ... min.
	48	2	24	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Janitor
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Atlantic City
(State or country) N. J.

PARENTS

10 NAME OF FATHER M/M

11 BIRTHPLACE OF FATHER (city or town)
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town)
(State or country)

14 Informant Mrs. Gray
(Address) 2448 Frances.

Filed JUL 19 1929 C. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) July 16th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest, autopsy or inquiry) find that said deceased came to Her death on the day stated above.

The CAUSE OF DEATH was as follows:

Accident

2nd degree burns.

(Duration) 1 yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) drop'd light under car while repairing (cause)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? 2448 Frances St

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Regular

(Signed) Herbert Corbin, M. D.

July 16th 1929 (Address) Coroner

State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Auburn Cem	July 19 1929

20 UNDERTAKER Samuel Hensley & Bro. ADDRESS 1128

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 47738 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47738

CERTIFICATE OF DEATH

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1030 Mc Cullohst. 11-24 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Laura A Faulkner

(a) RESIDENCE No. 1030 Mc Culloh ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 40 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	Colored	married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Sept 12, 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	41 42	10	4	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Domestic 37

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Davisville Md

PARENTS

10 NAME OF FATHER William Matthews

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Rachel Butler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant William Morris

(Address) 1030 Mc Culloh St

15 Filed JUL 19 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16th 1929

17 I HEREBY CERTIFY, That I attended deceased from June 14, 1929, to July 15th 1929.

That I last saw her alive on July 15th, 1929,

and that death occurred, on the date stated above, at 4.20 A. m.

The CAUSE OF DEATH* was as follows:

Cachexia Rectal Neoplasm

(duration) yrs. 2 mos ds.

CONTRIBUTORY (Secondary) Exhaustion & Anemia

(duration) yrs. mos. 4 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of June 20/29

Was there an autopsy? Yes Date of July 14/29

What test confirmed diagnosis? Clinical

(Signed) Geo. H. Kaufenbach, M. D.

1929 Address) 225 N. Monroe Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Lebanon Cemetery

DATE OF BURIAL: July 19, 1929

20 UNDERTAKER: Mrs. Kate R. Williams

ADDRESS 322 N Schroeder St

INFORMATION SHOULD BE CAREFULLY SUPPLIED. ANSWERS SHOULD BE PROPERLY CLASSIFIED. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47739

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 47739

1—PLACE OF DEATH

CITY OF BALTIMORE (No. 1300 William ST. 24-23 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Thomas Barry Goldsborough

(a) RESIDENCE NO. 1300 William St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary J. Goldsborough

6 DATE OF BIRTH (month, day, and year) 1/16/1905

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	24	6	29	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Line Repairman

(b) General nature of industry, business, or establishment in which employed (or employer) 186

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER Robert W. Goldsborough

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland.

12 MAIDEN NAME OF MOTHER Mabel K. Ford

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland.

14 Informant Mrs M J Goldsborough

(Address) 1300 William St

Filed JUL 19 1929 C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17, 1929

17 I HEREBY CERTIFY, That I attended deceased from Aug 1, 1928 to July 17, 1929

that I last saw him alive on July 17, 1929

and that death occurred, on the date stated above, at 10.10 P m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

CONTRIBUTORY (Secondary) (duration) yrs. 11 mos. 7 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam + X Ray

(Signed) Edward Norris M. D.

1928 1929 (Address) 107 East West St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral Cem

DATE OF BURIAL 7/20 1929

20 UNDERTAKER D. J. Foley Sons

ADDRESS 1318 Light

Important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 47740 HEALTH DEPARTMENT—CITY OF BALTIMORE 47740

CERTIFICATE OF DEATH.

118-02

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 938 N. Bond St. (St.) 7-13 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Helen Elizebeth Carter.

(a) RESIDENCE No. 938 N. Bond St. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 22 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Nov. 25. 1907

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	21	7		

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House work.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER Robert LeCarter.

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va.

12 MAIDEN NAME OF MOTHER Wanson Alice

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Elsie Carter

(Address) 938 n Bond St

15 Filed [illegible] 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18 1929

17 I HEREBY CERTIFY, That I attended deceased from July 11 1929 to July 18 1929.

that I last saw her alive on July 18 1929

and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction

(duration) yrs. mos 10 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? yes Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) H. S. McCord M. D.

July 19 1929 (Address) 2005 Druid Hill Ave

*State the Disease Causing Death, or in deaths from Violent Causes state (1) Means and Nature of Injury, and (2) whether Accidental Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL St Peters cemetery

DATE OF BURIAL July 22 1929

20 UNDERTAKER Edward Bryan

ADDRESS 631 orleans st

mation should be carefully supplied. Also whether CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47741 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47741

52

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 502 S. Ellwood ave St. 2 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Conrad Weinel

(a) RESIDENCE NO. 502 S. Ellwood ave St.
(Usual place of abode) WARD

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Divorced

a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 29-1873

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	55	7	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington D C.

PARENTS

10 NAME OF FATHER Wm. Weinel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Katharine Miller

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Katherine Weinel

(Address) 502 S Ellwood ave

15 Filed JUL 19 1929, 19 C. HAMPSON JONES, M. D.

Per H. Bell

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 1, 1922, to July 17, 1929, that I last saw h[illegible] alive on July 16, 1929, and that death occurred, on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Rheumatic Deformans

CONTRIBUTORY (Secondary) Endocarditis (duration) 7 yrs. 6 mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? — —

Did an operation precede death? — Date of —

Was there an autopsy? — —

What test confirmed diagnosis? By Ef

(Signed) Ed Electus Blades, M. D.

, 19 (Address) 7316 Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Carmel Cemetery	July 21 1929
20 UNDERTAKER George W. Finkler	ADDRESS 1737 E. Eager St

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47742

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47742

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 318 President ST., 13-5 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Cmelia Morisi

(a) RESIDENCE NO. 318 President ST.,

(Usual place of abode)

WARD

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? 33 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male.

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Louisa Morisi

6 DATE OF BIRTH (month, day, and year): June 18 1875

7 AGE: Years 54. Months Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Grocery

(b) General nature of industry, business, or establishment in which employed (or employer): Business

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER: Joseph Morisi

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy.

12 MAIDEN NAME OF MOTHER: Mary Tetarella

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: Louisa Morisi

(Address) 318 President St.

Filed JUL 19 1929, 19 C. HAMPSON JONES, M. D. Registrar

By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 17/29

17 I HEREBY CERTIFY, That I attended deceased from June 20, 1929, to July 17, 1929, that I last saw h— alive on July 16, 1929, and that death occurred, on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Exhaustion

CONTRIBUTORY (Secondary): Cancer of R Kidney (duration) 1 yrs. 3 mos. ds.

18 Where was disease contrarted if not at place of death? (duration) yrs. 2 mos. ds.

Did an operation precede death? yes Date of —

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Emily L. Richardson M. D.

July 18, 19 29 (Address) 1038 N Broadway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suiridal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Vincents — DATE OF BURIAL: July 19 29

20 UNDERTAKER: Kendall J. Hoppel — ADDRESS: 300 S. Edwards

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 47743

HEALTH DEPARTMENT—CITY OF BALTIMORE

179 ✓ E 47743

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Agnes Hospital E-4 St., ...Ward)

2-FULL NAME Michael Santora

(a) RESIDENCE NO. 309 S Edon St., ...Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 10 yrs. mos. ds. How long in U. S., if of foreign birth? 28 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Mary Santora

6 DATE OF BIRTH (month, day, and year) May 15 1898

7 AGE	Years	Months	Days	IF LESS than 1 day ....hrs. or ....min.
31	30	7	2	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Cement Worker
(b) General nature of industry, business, or establishment in which employed (or employer) 583
(c) Name of employer

9 BIRTHPLACE (city or town) .....
(State or country) Italy

PARENTS

10 NAME OF FATHER Peter Santora

11 BIRTHPLACE OF FATHER (city or town) .....
(State or country) Italy

12 MAIDEN NAME OF MOTHER Santomero

13 BIRTHPLACE OF MOTHER (city or town) .....
(State or country) Italy

14 Informant Mary Santora
(Address) 309 E Eden

15 Filed JUL 19 1929 C. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
First degree burns over entire body result from from Gasoline explosion
..... (duration) .....yrs. .....mos. .....ds.

CONTRIBUTORY .....
(Secondary)
..... (duration) .....yrs. .....mos. .....ds.

18 Where was disease contracted If not at place of death? .....

Did an operation precede death? ..... Date of .....

Was there an autopsy? .....

What test confirmed diagnosis? .....

(Signed) Chas. H. Brooks, M. D.

July 15 1929 (Address) 3601 3rd Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	July 20 1929
20 UNDERTAKER	ADDRESS
Wendell J. Lippel	300 N Eden

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47744 HEALTH DEPARTMENT—CITY OF BALTIMORE 3 E 47744

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals (T.B.) REGISTERED NO. 17-24

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Matisha Pressly

(a) RESIDENCE NO. 540 W. Preston st. ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Willie Pressly

6 DATE OF BIRTH (month, day, and year) 1905

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	24			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Maid c 10

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) North Carolina

PARENTS

10 NAME OF FATHER Walter Antry

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Anna Smith

13 BIRTHPLACE OF MOTHER (city or town) (State or country) North Carolina

14 Informant Hospital Records

(Address)

Filed JUL 19 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 16, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 1 19 29 to July 16 19 29, that I last saw her alive on July 16, 1929 and that death occurred, on the date stated above, at 6 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical and lab.

(Signed) Henry C. Smith M. D.

7-16 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	July 16 1929
20 UNDERTAKER	ADDRESS
Thomas E. Kelson	803 Pressman St

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 17288

E 17745

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

7-16-002

E 17745

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 7-9 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Daisy Hillen

(a) RESIDENCE NO. North Point Road near Northern Av ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 2 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 COLOR OR RACE: white

5 Single, Married, Widowed, or Divorced, (write the word): single

6 If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 11/25/28

7 AGE: Years | Months 7 | Days 24 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) [illegible]

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Calvin Hillen

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Daisy Fitchum

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUL 19 1929, 19 [illegible] HARRISON JONES, M. D. Registrar.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19-1929

17 I HEREBY CERTIFY, That I attended deceased from July 17, 1929, to July 19, 1929, that I last saw her alive on July 19, 1929 and that death occurred, on the date stated above, at 7 [illegible] m.

The CAUSE OF DEATH* was as follows:

Bacillary dysentery

(duration) yrs. mos. 7 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Not known

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Stool examination

(Signed) J. C. Goodwin, M. D.

7/19, 1929 (Address) J. H. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Carmel Cem — DATE OF BURIAL: July 22 1929

20 UNDERTAKER: Stephen J Falkowski Inc — ADDRESS: 1000 d. Kenwood Ave

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47746

CERTIFICATE OF DEATH

129

E 47746

1—PLACE OF DEATH

REGISTERED NO. 47746

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 724 N Fulton Ave ST., 16-23 WARD.

2—FULL NAME John Alphonso Finney

(a) RESIDENCE NO. 724 N. Fulton ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 0 mos. 0 ds. How long in U. S., if foreign birth 69 yrs. 1 mos. 3 ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Single

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: none

6 DATE OF BIRTH (month, day, and year): June 15 1860

7 AGE: Years 69 | Months 1 | Days 3 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired do

(b) General nature of industry, business, or establishment in which employed (or employer): Retired

(c) Name of employer: Retired

9 BIRTHPLACE (city or town) (State or country): Lexington Virginia

PARENTS

10 NAME OF FATHER: Alphonso N. Finney

11 BIRTHPLACE OF FATHER (city or town) (State or country): Lexington Virginia

12 MAIDEN NAME OF MOTHER: Mary A. Crawford

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Maryland

14 Informant: Mrs Elizabeth Hamilton Sister

(Address) 724 N. Fulton ave

15 Filed JUL 19 1929 19 C. HAMPSON JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7/18/29

17 I HEREBY CERTIFY, That I attended deceased from 6/18 19 29 to 7/18 19 29

that I last saw h~~im~~ alive on 7/18 19 29

and that death occurred, on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Cerebral arteriosclerosis

Cardiac hypertrophy

Chronic Interstitial nephritis. (duration) 8 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia Lobar.

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Examination

(Signed) J. T. Owens, M. D.

7/18 1929 (Address) 804 Carlton Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park Cemetery	July 20 1929
20 UNDERTAKER	ADDRESS
Stewart & Owens Co	Balto.

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

47747

CERTIFICATE OF DEATH

179 E 17747

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 2531 Wms Pratt ST. 20-69 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Henry Kynast

(a) RESIDENCE NO. 2521 Wms Pratt ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 48 yrs. — mos. — ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

(a) If married, widowed, or divorced HUSBAND of (or) WIFE of Rachel Kynast

6 DATE OF BIRTH (month, day, and year) Jan 8th 1856

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	73	6	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) Tomb Stone Cutter

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Switzerland

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Switzerland

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Switzerland

14 Informant Rachel Kynast

(Address) 2531 Wms Pratt St

15 Filed ..... 19 ..... Registrar

HAMILTON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18th 1929

17 I HEREBY CERTIFY That I attended deceased from July 17 1929 to July 18 1929 that I last saw him alive on July 18 1929 and that death occurred, on the date stated above, at 540 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis Chronic Nephritis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? Date of

Was there an autopsy? none

What test confirmed diagnosis? Clinical

(Signed) E Keller Hemming M. D.

7/19 1929 (Address) 2011 Fallsway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Western Cemetery	7/20/1929

20 UNDERTAKER Geo. Weber & Son ADDRESS 2503 Edmondson Ave

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47748

CERTIFICATE OF DEATH

118-002

E 47748

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) Balto. City Hosp. ST., 3-4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Adam H Larzlonde

(a) RESIDENCE NO. 715 S. Dallas ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
(51)	51			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ireland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Hospital Record

(Address)

15 Filed ..... 19 ..... HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/17/29

17

I HEREBY CERTIFY, That I attended deceased from 7/17 1929 to 7/17 1929

that I last saw h— alive on 7/17 1929

and that death occurred, on the date stated above, at 10:20 P. m.

The CAUSE OF DEATH* was as follows:

Intestinal obstruction

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Myocarditis (duration) 4 yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical

(Signed) H. H. Langston M. D.

7/18 1929 (Address) Balt. City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Rosary	July 20 1929

20 UNDERTAKER H W Ozazewski ADDRESS 1930 Fremont

Important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47749

CERTIFICATE OF DEATH.

101-001

E 47749

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 3615 Woodbine Ave (ST.) 28-64 (WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Roy Campbell Stewart

(a) RESIDENCE NO. 3615 Woodbine Ave ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred 53 yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of .....

6 DATE OF BIRTH (month, day, and year) Mch. 7-1874

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs or ..... min.
55	4	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Salesman

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Ga.

PARENTS

10 NAME OF FATHER Richard E Stewart

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Belle F. Murphy

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va

14 Informant Mrs C. Stewart

(Address) 3615 Woodbine Ave

15 Filed JUL 19 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18th 1929.

17 I HEREBY CERTIFY, That I attended deceased from June 10th, 1929, to July 18th, 1929, that I last saw h[illegible] alive on July 18th, 1929, and that death occurred, on the date stated above, at 11.55 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage

(duration) yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) yrs. 1 mos. ..... ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edward Schenk, M. D.

July 17, 1929 (Address) 711 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Greenmount Cem	July 20 1929

20 UNDERTAKER Chas. E. Branch & Son

ADDRESS Madison

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47750

CERTIFICATE OF DEATH.

90 E 47750

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2939 Clifton Ave ST. 15-67 (WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Amelia C. Wilson

(a) RESIDENCE NO. 2939 Clifton Ave ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred 75 yrs. ... mos. ... ds. How long in U. S., if of foreign birth? ... yrs. ... mos. ... ds.
(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Philip W. Wilson

6 DATE OF BIRTH (month, day, and year): Feb. 2-1854

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs or ... min.
75	5	16	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: John Warner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Sophia Keller

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Philip W. Wilson
(Address) 2939 Clifton Ave

15 Filed JUL 19 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 18, 1929

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1929, to July 18, 1929, that I last saw her alive on July 18th, 1929, and that death occurred, on the date stated above, at 11.40 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral endarteritis

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Myocarditis

(duration) 5 yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? no Date of .....

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Gustave C. Dohme, M. D.

7/18/1929 (Address) 3014 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cem. DATE OF BURIAL: July 20 1929

UNDERTAKER: Chas. E. Franck ADDRESS: 817 Madison Ave

Cor.—10-10-29—A Co.—100 Bks.

E 47751

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47751

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Fort Ave & Richardson St. 24-35-90 St., Ward)

2-FULL NAME James C.Cowlie.

(a) RESIDENCE NO. 1104 Haubert St. St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. (If non-resident give city or town and State) How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White.	Do not know.

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ---------

6 DATE OF BIRTH (month, day, and year) Do not know.

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	48	----	----	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Seaman.
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Scotland.

PARENTS

10 NAME OF FATHER Do not know.

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Do not know.

12 MAIDEN NAME OF MOTHER Do not know.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Do nog know.

14 Informant Police Report. S.D.
(Address)

15 Filed JUL 19 1929 HAMILTON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 2, 1929 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Organic disease of the Heart.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No. Date of

Was there an autopsy? No.

What test confirmed diagnosis? Inquiry

(Signed) Otto M Leinrodt, M. D.

7/18 1929 (Address) 1017 E. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL PUBLIC CEMETERY.

DATE OF BURIAL July 19 1929

20 UNDERTAKER Commissioner Health.

ADDRESS

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

27 5282
E 47752

CERTIFICATE OF DEATH

101-001

E 47752

1—PLACE OF DEATH

REGISTERED NO. 16-776

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. [illegible] WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Clarence ~~Caldwell~~ Culver

(a) RESIDENCE NO. 830 Lemon St ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Black	Single

a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 5/15/28

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	1	2	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None. ~~Md~~

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Roy ~~Caldwell~~ Culver

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sadie Garner

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N C

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUL 13 1929, 19 [illegible] Registrar

C. HENDERSON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17-1929

17

I HEREBY CERTIFY, That I attended deceased from May 13, 1929, to July 17, 1929.

that I last saw him alive on July 17, 1929

and that death occurred, on the date stated above, at 7 08 P m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia.

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Empyema, Peritonitis

(duration) yrs. 2 mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? Yes Date of June 9, 1929

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) V. C. Goodwin, M. D.

7/17, 1929 (Address) J. H. Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt. Auburn

DATE OF BURIAL 7/20/1929

20 UNDERTAKER Wm. Geo. H. Holland

ADDRESS 1632 Druid Hill

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47753

CERTIFICATE OF DEATH

E 47753 90 E 47753

1—PLACE OF DEATH Baltimore City Hospitals 26-2 REGISTERED NO.

CITY OF BALTIMORE: (No. ..... ST. ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Dorsch

(a) RESIDENCE NO. 235 S. Highland Ave. ST., ... WARD
(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? ? yrs. ? mos. ? ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Unknown

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) ?
(State or country) Unknown

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) ?
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) ?
(State or country) Unknown

14 Informant Records of
(Address) Baltimore City Hospitals

15 Filed ....., 19 .... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 13, 19 29, to July 19, 19 29, that I last saw him alive on July 19, 19 29 and that death occurred, on the date stated above, at 7:30 A.m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Chronic

..... (duration) ? yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) Arteriosclerosis: Coronal

Thrombosis (duration) 2? yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? P.C. Histo. - Autopsy

(Signed) Marvin M. McLean, M. D.

7-19, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
St Pauls Reformed Cem	July 21 1929
20 UNDERTAKER	ADDRESS
Leo G. Brooks	1723 Patterson Ave

important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 47754

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47754

REGISTERED NO. 185

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. St. Joseph Hospital St 10-14 Ward)

2-FULL NAME Nellie Byrnes De Martin

(a) RESIDENCE NO. 1003 E. Chase St St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Andrew De Martin

6 DATE OF BIRTH (month, day, and year) Oct 31/1868

7 AGE	Years	Months	Days	If LESS than 1 day hrs. or min.
	60	8	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) 0
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER John McGovern

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland

12 MAIDEN NAME OF MOTHER Margaret Burns

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland

14 Informant Mrs Wm. Farley
(Address) 250 Overland Ave

15 Filed JUL 20 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19/29 192

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:
Shock-Multiple Fractures including Spine- Accidently fell from window of residence while hanging out laundry 7/17/29

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) J. H. Cullen, M. D.

7/19/29 (Address)

*State the Disease Causing Death, or In deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Marys, Govans — DATE OF BURIAL 7/22 1929

20 UNDERTAKER D. M. Cook — ADDRESS 1217 N. Howard St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

Campbell Keagle & Hannon

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47755

CERTIFICATE OF DEATH

1503

E 47755

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE (No. 209 W McComas St., 23-37 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Madalene Elmore

(a) RESIDENCE NO. 209 W. McComas ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred life yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE W

5 Single, Married, Widowed, or Divorced, (write the word) Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) June 4-27

7 AGE

Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
1		24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work repair

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Charles Elmore

11 BIRTHPLACE OF FATHER (city or town) Balto (State or country) Md

12 MAIDEN NAME OF MOTHER Earlsmith

13 BIRTHPLACE OF MOTHER (city or town) Md (State or country)

14 Informant Earl E. Elmore

(Address) 209 W McComas

15 Filed JUL 20 1929 C. HAMPSON JONES, Registrar

By [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18/29

17 I HEREBY CERTIFY, That I attended deceased from June, 1927, to July 18, 1929

that I last saw h[illegible] alive on July 17, 1929

and that death occurred, on the date stated above, at 3-45 P.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) R. E. Campbell M. D.

July 19 29 (Address) 1644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Lorraine County	July 20-29

20 UNDERTAKER [illegible] ADDRESS [illegible]

Important. See instructions on back of certificates.

Spec.—6-9-13—H. P. Co.—1000 Bks.

E 47756

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47756

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 918 McCulloh (St.) (11-24 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Eliza Jackson

(a) RESIDENCE. No. 918 McCulloh St., WARD.

(Usual place of abode) (If nonresident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Col.

5 Single, Married, Widowed, or Divorced (write the word): Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of: Winfield Jackson

6 DATE OF BIRTH (month, day, and year): [illegible] 1868

7 AGE: Years 61; Months; Days; If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer: Self

9 BIRTHPLACE (city or town) (State or country): Va.

PARENTS

10 NAME OF FATHER: Noble Raine

11 BIRTHPLACE OF FATHER (city or town) (State or country): Va

12 MAIDEN NAME OF MOTHER: Mary Morris

13 BIRTHPLACE OF MOTHER (city or town) (State or country): [illegible] County

14 Informant: Jamie Johnson (Address) 918 McCulloh St

15 Filed [illegible] 19 C. HAMPSON JONES, Registrar

Per [illegible]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 17- 1929

17 I HEREBY CERTIFY, That I attended deceased from July 11- 1929, to July 17- 1929, that I last saw h[illegible] alive on July 16- 1929, and that death occurred, on the date stated above, at 5 A. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage with left hemiplegia

(duration) — yrs. — mos. 3 ds.

CONTRIBUTORY (Secondary) Arteriosclerosis & Myocarditis (duration) not known yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no-

What test confirmed diagnosis? Physical tests

(Signed) Chas. J. Keller, M. D.

7/17, 1929 (Address) 222 W. Monument

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Richmond. Va — DATE OF BURIAL: July 20 1929

20 UNDERTAKER: John H. Toadvine — ADDRESS 1027 Hamilton

JUL 20 1929

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47757 HEALTH DEPARTMENT—CITY OF BALTIMORE 74-001 E 47757

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 1021 Union Ave ST. 13-52 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James E. Hamilton

(a) RESIDENCE NO. 1021 Union Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
male	white	married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Emma F. Hamilton

6 DATE OF BIRTH (month, day, and year) Oct 2, 1868

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	60	9	16	

8 OCCUPATION OF DECEASED

(a) Trade, professinn or particular kind of work Laborer

(b) Gencral nature of industry, bnsiness, nr establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) md.

PARENTS

10 NAME OF FATHER John Hamilton

11 BIRTHPLACE OF FATHER (city or town) md. (State or country)

12 MAIDEN NAME OF MOTHER Margaret Crawford

13 BIRTHPLACE OF MOTHER (city or town) md. (State or country)

14 Informant Emma F. Hamilton

(Address) 1021 Union Ave

15 Filed JUL 20 1929 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 15 1929

17 I HEREBY CERTIFY, That I attended deceased from July 8, 1929, to July 15, 1929

that I last saw h alive nn July 15, 1929

and that death occurred, on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Pulmonary Edema

(duration) yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Cardiac Hypertrophy

(duration) yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation preecde death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Physical Signs

(Signed) Frank H Martin, M. D.

, 19 (Address) 4037 Falls Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon Park	July 20 19
20 UNDERTAKER	ADDRESS
P. Lawrence Kelly	1524 Eutaw Pl.

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47758

CERTIFICATE OF DEATH

31 E 47758

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. Baltimore City Hospitals ST. 1427 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Lottie Jones

(a) RESIDENCE NO. 1433 Edison ave. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Unknown mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Separated

5a If married, widowed, or divorced BUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) 1897

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	32			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Cook

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER James White

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER Ida ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Virginia

11 Informant Hospital Records
(Address)

15 Filed 7-20, 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 3, 1929, to July 17, 1929, that I last saw her alive on July 17, 1929 and that death occurred, on the date stated above, at 7.40 a. m.

The CAUSE OF DEATH* was as follows:

Pulmonary tuberculosis

(duration) Unknown yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical and autopsy

(Signed) Henry Smith M. D.

7-18, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn Cem

DATE OF BURIAL: 7-20 1929

20 UNDERTAKER: Dennis Eastes

ADDRESS: 946

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47759

E 47759

CERTIFICATE OF DEATH

1—PLACE OF DEATH Mercy Hospital REGISTERED NO. 29

CITY OF BALTIMORE: (No. ST 11-2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frederick Parker

(a) RESIDENCE NO. 1218 Madison Ave WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Col	unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1884

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or .... min.
	45	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer) O&S

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) unknown

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) unknown

14 Informant Lillian Odell Duff

(Address) 623 Madison Ave

15 Filed JUL 29 1929, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-15-29

17 I HEREBY CERTIFY, That I attended deceased from 6-28, 19 29, to 7-15, 19 29

that I last saw him alive on 7-15, 19 29

and that death occurred, on the date stated above, at 11 45 P. m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis cardio-vascular renal disease

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac decompensation

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) David Feuer, M. D.

, 19 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	7-20 19 29

20 UNDERTAKER Hamm Carson Co

ADDRESS Ft

important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Bks.

E 47760 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47760

CERTIFICATE OF DEATH.

101-00

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hospital (10-14 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Louise White

(a) RESIDENCE No. 806 Argyle ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 26 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Clarence White

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	26?	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balt. Md

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Husband

(Address)

15 Filed JUL 20 1929, 19 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18 1929

17

I HEREBY CERTIFY, That I attended deceased from July 16, 1929, to July 18, 1929, that I last saw h[illegible] alive on July 18, 1929, and that death occurred, on the date stated above, at 4 15 A m.

The CAUSE OF DEATH* was as follows:

Lobar Pneumonia

(duration) yrs. mos 6 ds.

CONTRIBUTORY (Secondary) Acute Rheumatism

(duration) yrs. ? mos. ds.

18 Where was disease contracted if not at place of death? Undetermined

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) George MacDonald, M. D.

, 19 (Address) Provident Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Auburn	July 20 1929
20 UNDERTAKER	ADDRESS
S. Theodore White	113 Walbrook

CAUSE OF DEATH in plain terms, so that it may be properly TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47761

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

57 E 47761

REGISTERED NO.

1—PLACE OF DEATH St Joseph Hospital

CITY OF BALTIMORE: (No. Lanvale & Calvert ST., 8 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Newton L. Fowler

(a) RESIDENCE NO. 1436 N Broadway ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 23 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married, Widowed, or Divorced~~ (write the word)
male	white	widowed

5a If ~~married, widowed, or divorced~~ HUSBAND of (or) ~~WIFE~~ of Katherine M. Fowler

6 DATE OF BIRTH (month, day, and year) Aug 21, 1882

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
46 47		10	28	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Butcher 03

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Carroll Co, Md

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Carroll Co., Md

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't Know

14 Informant Newton L. Fowler

(Address) 3009 Independent St

15 Filed ..., 19 ...

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19, 1929

17 I HEREBY CERTIFY, That I attended deceased from 7-16-29, 19..., to 7-19-29, 19..., that I last saw h alive on 7-19-29, 19..., and that death occurred, on the date stated above, at 5 m.

The CAUSE OF DEATH* was as follows:

Diabetes Mellitus

(duration) 6 yrs. mos. ds.

CONTRIBUTORY (Secondary) Anemia 3

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of None

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy

(Signed) I. W. Hendrix, M. D.

, 19 (Address) Jos Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Parkwood Cemetery — DATE OF BURIAL July 22 19 29

20 UNDERTAKER Robt L. Turner — ADDRESS 1442 N Broadway

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 17762

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 17762

CERTIFICATE OF DEATH.

31

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1111 S. Elinton ST. (Ward) Not

2-FULL NAME George J. Kraus

(a) RESIDENCE NO. 1114 S. Elinton ST., 26 WARD
(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. mos. ds. How long in U. S., if of foreign birth? ? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Catherine A. Kraus

6 DATE OF BIRTH (month, day, and year): Oct. 8th 1877

7 AGE — Years: 49 — Months: 9 — Days: 9 — If LESS than 1 day, hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Acrobat in

(b) General nature of industry, business, or establishment in which employed (or employer): Show. 08

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: Catherine A. Kraus
(Address): 111 S. Elinton St

15 1929 . 19 HAMPSON JONES, M. D.
Coroner

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 17 1929

17 I HEREBY CERTIFY, That I attended deceased from June 17, 19 29, to July 17, 19 29, that I last saw h im alive on July 14, 19 29, and that death occurred, on the date stated above, at 10½ p m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary): Myocardial Insufficiency

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical Signs

(Signed) H. B. Bronushas M. D.

7-18, 19 29 (Address) 3037 O'Donnell St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Sacred Heart — DATE OF BURIAL: July 22 19 29

20 UNDERTAKER: [illegible] — ADDRESS: [illegible]

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47763 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47763

CERTIFICATE OF DEATH

141

1—PLACE OF DEATH

REGISTERED NO. 22-33

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 1700 Hanover ST. WARD

2—FULL NAME Frieda L. Buckmaster

(a) RESIDENCE NO. 316 Patapsco ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of: Armeanius F.

6 DATE OF BIRTH (month, day, and year): July 11, 1893

7 AGE — Years: 36 Months: 0 Days: 7 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Elmer E. Clark

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Jennie L. Jacobs

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: F. L. Buckmaster

(Address) 316 Patapsco St.

15 Filed JUL 20 1929 C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 18 - 1929

17 I HEREBY CERTIFY, That I attended deceased from July 15 1929 to July 18 1929

that I last saw her alive on July 17 1929

and that death occurred, on the date stated above, at 6 a m.

The CAUSE OF DEATH* was as follows:

Pelvic inflammatory disease

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage from rectum

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Wm. Lee Willis M. D.

19 (Address) 1325 St. Charles St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Western Cemetery — DATE OF BURIAL: July 20, 1929

20 UNDERTAKER: Margaret S. Flynn — ADDRESS: 14 W. Preston St.

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47764 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47764

Dr Richardson 1129 25th St

1295

CERTIFICATE OF DEATH

12-51

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 121 W. 27th St.) (WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Annie E. Carey

(a) RESIDENCE NO. 121 W. 27th ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Edward A. Carey

6 DATE OF BIRTH (month, day, and year): Dec 25, 1863

7 AGE — Years: 65 | Months: 6 | Days: 24 | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: At Home

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Miles P. Byrne

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ireland

12 MAIDEN NAME OF MOTHER: Annie Byrnes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ireland

14 Informant: Miles M. Carey

(Address): 121 W. 27th St

15 Date: JUL 20 1929 19 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 19. 1929

17 I HEREBY CERTIFY, That I attended deceased from June 5 19 29, to July 19 19 29

That I last saw h[illegible] alive on July 19 19 29

and that death occurred, on the date stated above, at 5a m.

The CAUSE OF DEATH* was as follows:

1 Pneumonia

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Embolism

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. E. Wahrenholz Jr M. D.

19 (Address) 1120 W. 25th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Cathedral

DATE OF BURIAL: 7/22 19 29

20 UNDERTAKER: H. M. Cook

ADDRESS: 1217 E. Fayette St

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47765 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47765

CERTIFICATE OF DEATH

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1511 N. Milton av ST., 8-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Anna C. Trueschler

(a) RESIDENCE NO. 1511 N. Milton av ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 70 yrs. 10 mos. 2 ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Philip Trueschler

6 DATE OF BIRTH (month, day, and year) Sept 16, 1858

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	70	10	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md.

PARENTS

10 NAME OF FATHER John Wellhein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER Mary Franz

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Joseph C Trueschler (Son)

(Address) 1511 N. Milton av

Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18. 1929

17 I HEREBY CERTIFY, That I attended deceased from June 23, 1929, to July 18, 1929.

that I last saw her alive on July 18, 1929

and that death occurred, on the date stated above, at 2 25 P m.

The CAUSE OF DEATH* was as follows:

Uraemia Coma. 4 days

Hypertension ? Arterio Sclerosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 21 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Uraemia + Albumen

(Signed) Thos. F. Stevens, M. D.

7/19, 1929 (Address) 1818 Hartford Rd

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer Cemetery	July 22 1929

20 UNDERTAKER William G Schaeffer ADDRESS 1816 Monument

JUL 20 1929 BALTIMORE, MARYLAND

important. See instructions on back of certificates.

Spec.—1-12-23—3M.—500 Bks.

E 47766

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47766

CERTIFICATE OF DEATH.

111-60

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Vol. America Hospital ST., WARD 26

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME John J. Norton

(a) RESIDENCE NO. 17 N. Pearl ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 69 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) May 4. 1860

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	69	2	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Michael Norton

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland,

12 MAIDEN NAME OF MOTHER Mary Quinn

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ireland

14 Informant Mrs E. Madigan

(Address) 1123 N. Milton ave.

15 Filed ..., 19 C. HAMPSON JONES, M. D. Registrar

JUL 20 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1929

17

I HEREBY CERTIFY, That I attended deceased from May 31, 1929, to July 19, 1929, that I last saw him alive on July 19, 1929, and that death occurred, on the date stated above, at 9-45 a m.

The CAUSE OF DEATH* was as follows:

Pneumonia following operation for Pyloric Ulcer

(duration) ... yrs. ... mos. 10 ds.

CONTRIBUTORY (Secondary) Ulcer of Pylorus

(duration) 2 yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? yes Date of 7-8-29

Was there an autopsy? no

What test confirmed diagnosis? —

(Signed) A. F. Conrey, M. D.

7-19 1929 (Address) Vol. America Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL New Cathedral — DATE OF BURIAL July 23 1929

20 UNDERTAKER William J. Schaefer — ADDRESS 1816 mount

CAUSE OF DEATH in plain terms, so that it may be properly classified. EXACT STATEMENT IS VERY important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47767 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47767.

38

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. ST. 22-30 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Alice Dunlap

(a) RESIDENCE NO. 653 Dover ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Henry Dunlap

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	50 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) ? North Carolina

PARENTS

10 NAME OF FATHER Frank Watkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) ? North Carolina

12 MAIDEN NAME OF MOTHER Esther Morgan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ? North Carolina

14 Informant Records of

(Address) Baltimore City Hospitals

15 Filed July 20 1929 C. HAMPSON JONES, M. D. Per [illegible] (Registrar)

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 3, 1929 to July 17, 1929

that I last saw her alive on July 17, 1929

and that death occurred, on the date stated above, at 7:15 P. m.

The CAUSE OF DEATH* was as follows:

Syphilis

Myocarditis, chronic Acute Circulatory

Aortic insufficiency

(duration) 2½ yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage into cerebrum & Pneumonia, Left (duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? History C.E. Autopsy Lab

(Signed) Warren H. McLean, M. D.

7-18, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cemetery	July 21 1929
20 UNDERTAKER	ADDRESS 325 E Lafayette St
Thos Kath & Williams	

important. See instructions on back of certificates.

Cor.—10-16-29—A Co.—100 Blks.

E 47768

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

66 E 47768

REGISTERED NO. 22-30

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 218 S. Eutaw St., Ward)

2-FULL NAME John Zaromski

(a) RESIDENCE NO. 218 S. Eutaw St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 13 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	37			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Lithuania

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Mr. George Gaston
(Address) 213 S. Place St.

15 Filed ..., 19.. H. A. M. P. S. O. N. J. O. N. E. S., M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquiry (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Alcoholism

(duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary)

(duration) ..yrs. ..mos. ..ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Edgar Zeller M. D.

7/19, 1929. (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross, A. A. Co.

DATE OF BURIAL 7/20 1929

20 UNDERTAKER L. T. Russelburg

ADDRESS 2620 5th Ave

JUL 20 1929

tion should be carefully supplied. AGE should be stated EXACTLY. THOROUGHLY answer each question OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

(duration) ... yrs. ... mos. ... ds.

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown
(State or country)

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) Unknown
(State or country)

PARENTS

Informant Mrs. George Gaston
(Address) 213 S. Paca St.

19 HAMPSON JONES, M. D.
29 217 Registrar

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Eugene Fiteri M. D.

7/19 1929. (Address) 2739 Eastern Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross, A. A. Co.

DATE OF BURIAL 7/20 1929

20 UNDERTAKER L. T. Fusselbaugh

ADDRESS 2620 St Paul

Spec.—1-12-23—M&T—500 Bks.

47769

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

100-E 47769

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 201 N. Spring ST. 10-9 WARD)

2-FULL NAME Dowtty Jones

(a) RESIDENCE NO. 201 N Spring ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 7 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX F

4 COLOR OR RACE Col

5 Single, Married, Widowed, or Divorced, (write the word) S

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year)

7 AGE Years Months 7 Days If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto
(State or country)

PARENTS

10 NAME OF FATHER John Jones

11 BIRTHPLACE OF FATHER (city or town) Va.
(State or country)

12 MAIDEN NAME OF MOTHER Emily Parton

13 BIRTHPLACE OF MOTHER (city or town) Va
(State or country)

14 Informant John Jones
(Address) 201 N Spring St

15 Filed 20 1929 . 19 C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-17 1929

17

I HEREBY CERTIFY, That I attended deceased from July 15, 1929, to July 17, 1929, that I last saw her alive on July 17, 1929, and that death occurred, on the date stated above, at 2 30 PM m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) ... yrs. ... mos ... ds.

CONTRIBUTORY (Secondary)

(duration) ... yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy? no

What test confirmed diagnosis?

(Signed) Calvin B LeCompte M. D.

, 19 (Address) 814 N Carlton St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Astrum Cemetery

DATE OF BURIAL July 20 1929

20 UNDERTAKER Edward Bryan

ADDRESS 1631 Orleans St

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

47770

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47770

CERTIFICATE OF DEATH

199

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Johns Hopkins Hospital St. 6-4 Ward)

2-FULL NAME Robert Banks

(a) RESIDENCE NO. 1535 Orleans St St., Ward .....

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 14 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
M	B	Married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of Mary Banks

6 DATE OF BIRTH (month, day, and year) 1886

7 AGE	Years	Months	Days	IF LESS than 1 day ..hrs. or ..min.
	43			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Laborer
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) La.

PARENTS

10 NAME OF FATHER Andrew Banks

11 BIRTHPLACE OF FATHER (city or town)
(State or country) La

12 MAIDEN NAME OF MOTHER Louisa Jones

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) La

14 Informant Mary Banks
(Address) 1535 Orleans St

15 Filed ....., 19.... HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 17/29

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Hemorrhage- Fractured Skull

Homicide

(duration) ..yrs. ..mos. ..ds.

CONTRIBUTORY (Secondary)

(duration) ..yrs. ..mos. ..ds.

18 Where was disease contracted If not at place of death?

Did an operation precede death? yes Date of 7/17/29

Was there an autopsy? Yes

What test confirmed diagnosis?

(Signed) [signature] M. D.

7/18/29 (Address) 503 E. North Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL National Cemetery

DATE OF BURIAL July 1929

20 UNDERTAKER [signature]

ADDRESS 1631 Orleans St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIAN should sign OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

JUL 29 1929 C. HAMPSON JONES, M. D.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47771 HEALTH DEPARTMENT—CITY OF BALTIMORE 90 E 47771

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. St Joseph's Hospital STREET 27-45 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Lemmon.

(a) RESIDENCE NO. St. Michaels Rectory WARD
(Usual place of abode) Oriolea. Md
(If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of —
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) May 9 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	70	2	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work —

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER Jonas Hall Lemmon

11 BIRTHPLACE OF FATHER (city or town) (State or country) Richmond Va

12 MAIDEN NAME OF MOTHER Catherine King

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Washington D C

14 Informant Mrs Wm Lukens
(Address) 2402 Guilford Ave

15 Filed ....., 19.... C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18 1929.

17 I HEREBY CERTIFY, That I attended deceased from June 27, 1929, to July 18, 1929, that I last saw h.. alive on July 18, 1929, and that death occurred, on the date stated above, at 11 P.M., ...m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? at Home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) J. Albert Bayle, M. D.

, 19 (Address) 3100 Belair Road.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	July 22 1929
20 UNDERTAKER	ADDRESS
Mary M Wedefeld	501 E 22nd St

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47772

CERTIFICATE OF DEATH.

161-001 E 47772

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1554 Boyle ST. (or HOSPITAL) 24-34 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Infant of Margaret Elizabeth Whites

(a) RESIDENCE NO. 1554 Boyle ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): July 20/29

7 AGE: Years | Months | Days | If LESS than 1 day 2 hrs or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: Chas. B. White

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md

12 MAIDEN NAME OF MOTHER: Margaret Gibson

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md

14 Informant: Chas. B. White

(Address) 1554 Boyle St.

15 Filed JUL 21 1929 A. HANSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 20 1929

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1929, to July 20, 1929, that I last saw him alive on July 20, 1929, and that death occurred, on the date stated above, at 11 A m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(7760)

CONTRIBUTORY (Secondary) Extinction (duration) yrs. mos. ds.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

Signed C. P. Campbell M. D.

(Address) 644 Hanover

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery | DATE OF BURIAL: 7/20 1929

20 UNDERTAKER: Chas. Stevens | ADDRESS: Fortville & Hull Sts

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47773

CERTIFICATE OF DEATH

X 86.001 E 47773

1—PLACE OF DEATH Mercy Hospital

CITY OF BALTIMORE: (No. ST. 4-1 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John Lewis

(a) RESIDENCE NO. Atlanta Georgia ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 10 ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 6 1893

7 AGE — Years: 36 | Months: 4 | Days: 13 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Warrant Officer

(b) General nature of industry, business, or establishment in which employed (or employer): U. S. Army

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Ala

PARENTS

10 NAME OF FATHER: Wm J. Lewis

11 BIRTHPLACE OF FATHER (city or town) (State or country): Ga

12 MAIDEN NAME OF MOTHER: Mattie Mae Espy

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Ala

14 Informant: Wm Roy Lewis

(Address) Eufaula Ala

15 Filed JUL 21 1929, 19 — HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 15, 1929

17 I HEREBY CERTIFY, That I attended deceased from 7-15, 1929, to 7-15, 1929, that I last saw h[im] alive on 7-15, 1929 and that death occurred, on the date stated above, at 10 45 P. m.

The CAUSE OF DEATH* was as follows:

Acute Purulent Otitis Media

(duration) yrs. mos. 14 ds.

CONTRIBUTORY (Secondary) Pneumococcus Meningitis

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of ——

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J Leyko, M. D.

7-19, 1929 (Address) Mercy Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Eufaula Ala — DATE OF BURIAL: 7/29, 1929

20 UNDERTAKER: S. Lipman & Bro — ADDRESS 127 Bolton St

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47774 HEALTH DEPARTMENT—CITY OF BALTIMORE ✓ 47774 49 E 47774

CERTIFICATE OF DEATH

1—PLACE OF DEATH St. Joseph Hosp. REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. Paulson Place ST. W. 14 WARD)

2—FULL NAME Abraham Mastas

(a) RESIDENCE NO. 1613 Bolton Street ST., ... WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	white	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Annette Mastas

6 DATE OF BIRTH (month, day, and year) 1873

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	56	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Tailor

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Solomon Mastas

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Rose

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Mrs Mastas (Address) 1502 Druid Hill Ave

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 29

17 I HEREBY CERTIFY, That I attended deceased from 6-26, 19 29, to 7-19, 19 29, that I last saw h... alive on 7-19, 19 29, and that death occurred, on the date stated above, at 1:00 m.

The CAUSE OF DEATH* was as follows:

Cancer of Rectum

..... (duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

..... (duration) ..... yrs. ..... mos. 7 ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? Yes Date of 7 17 29

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H B Thurnwald, M. D.

At 19 St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Bals Hebrew Cem	July 21 19 29
20 UNDERTAKER	ADDRESS
Jack Lewis	1439 E Balto St

C. HAMPSON JONES, M. D.
Registrar

important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 47775

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

47778

E 47775

1-PLACE OF DEATH West Baltimore General 90 REGISTERED NO.

CITY OF BALTIMORE: (No.) ST. 15-68 WARD

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Goldie Yelfelt.

(a) RESIDENCE No. 1702 N. Smallwood ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 19 yrs. mos. ds. How long in U. S., If of foreign birth? 19 yrs. mos. ds.

(If non-residents give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fmale

4 COLOR OR RACE: white

5 Single, Married, Widowed or Divorced, (write the word): Divorced

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): 1880

7 AGE: Years 48 Months — Days — If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (City or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Untown

11 BIRTHPLACE OF FATHER (City or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Rosie Stella

13 BIRTHPLACE OF MOTHER (City or town) (State or country): Russia

14 Informant (Address): Jack Brown 900 E. Lombard St

15 Filed 1929 H. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 19, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 3, 1929, to July 19, 1929, that I last saw h[illegible] alive on July 19, 1929 and that death occurred, on the date stated above, at 7:55 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Valvular Heart Disease - Mitral.

(duration) 7 yrs. mos ds.

CONTRIBUTORY (Secondary) Gangrene - Left Foot

(duration) yrs. mos. 19 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) J. Madonna, M. D.

7/19, 1929 (Address) West Balto. General.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Herman Lasedale — DATE OF BURIAL: July 21, 1929

20 UNDERTAKER: Jack Levis — ADDRESS: 1439 Eutaw St

L 21 1929

TION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

47776
E 47776
1—PLACE OF DEATH

CERTIFICATE OF DEATH

27-002

42776
E 47776

REGISTERED NO.

CITY OF BALTIMORE: (No. 2023 West Pratt St. 7-30-28 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Fannie Karlinsky

(a) RESIDENCE NO. 2023 W. Pratt Street (Usual place of abode) WARD

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if foreign birth 45 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Hyman Karlinsky

6 DATE OF BIRTH (month, day, and year) 1860

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	69	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Harry Blum

(Address) 307 W. Balt St

15 Filed JUL 2T 1929, 19

C. HAMPSON JONES, M. D.
Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 29

17 I HEREBY CERTIFY, That I attended deceased from July 17 29, 1929, to July 20, 1929, that I last saw her alive on July 20 1929 and that death occurred, on the date stated above, at 6.30 P.M.

The CAUSE OF DEATH* was as follows:

Bronchopneumonia (terminal)

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Thrombosis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) L Printzlau, M. D.

7/21, 1929 (Address) 2220 Eutaw Pl

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Shaarei Sholom Cem	July 21 29

20 UNDERTAKER Jack Lewis ADDRESS 1439 E Balt St

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 47777

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

47777

74-001

E 47777

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Franklin Square Hosp ST. 23rd WARD)

2-FULL NAME Gertrude Sala

(a) RESIDENCE No. 2007 Eager St. ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 28 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Salvador Sala

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	80			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Guarino Giuseppe

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER Josephine ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Vincent Sala (Address) 2007 Eager St.

15 Filed JUL 21 1929, 19 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/19 1929

17 I HEREBY CERTIFY, That I attended deceased from 7/18/29, 19, to 7/19, 19 29,

that I last saw h alive on 7/19, 19 29,

and that death occurred, on the date stated above, at 2.20 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral hemorrhage with cerebral arterio - sclerosis.

(duration) yrs. mos 5 ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Symptoms

(Signed) Arthur Rathmann M. D.

7-19-1929 (Address) Franklin Sq Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer — DATE OF BURIAL July 22 1929

20 UNDERTAKER Fred Brockton — ADDRESS 1900 Eutaw

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-20-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

47778

E 47778

CERTIFICATE OF DEATH

E 47778

1—PLACE OF DEATH St Joseph's Hospital REGISTERED NO. 90

CITY OF BALTIMORE: (No. 3-5 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Nunzio Messina

(a) RESIDENCE NO. 117 S. High ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 15 yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Josephine Matassa

6 DATE OF BIRTH (month, day, and year) april 17 1866

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	63	3	2	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Labor

(b) General nature of industry, business, or establishment in which employed (or employer) City

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Italy

PARENTS

10 NAME OF FATHER Giovanni Messina

11 BIRTHPLACE OF FATHER (city or town) (State or country) Italy

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Italy

14 Informant Josephine Messina
(Address) 117 S. High St.

15 Filed ....., 19.... C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19-1929

17 I HEREBY CERTIFY, That I attended deceased from July 13, 1929, to July 19, 1929, that I last saw h.. alive on July 19, 1929 and that death occurred, on the date stated above, at 4 25 P m.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Edema

(duration) yrs. 3 mos. ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) M Kilcullen, M. D.

, 19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cemetery — DATE OF BURIAL July 22 1929

20 UNDERTAKER George L. Rueth — ADDRESS 1735 Harford Av

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47779

HEALTH DEPARTMENT—CITY OF BALTIMORE

47779 E 47779

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. 1520 N. Bethel ST. 8-17 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Gwin

(a) RESIDENCE NO. 1520 N. Bethel ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? _ yrs. _ mos. _ ds.

important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ___ hrs. or ___ min.
	69			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Janitor

(b) General nature of industry, business, or establishment in which employed (or employer): ?

(c) Name of employer: ?

9 BIRTHPLACE (city or town) (State or country): ? Virginia

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town): ? (State or country) Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town): ? (State or country) Unknown

14 Informant: Records of

(Address) Baltimore City Hospitals

15 Filed JUL 21 1929, 19 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 15, 19 29 to July 18, 19 29, that I last saw him alive on July 18, 19 29 and that death occurred, on the date stated above, at 3:30 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis, Arteriosclerosis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Hemorrhage into Cerebrum, Rt

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Post. M.E. autopsy

(Signed) Marion M McLean, M. D.

7/19, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Baltimore County	July 22 1929.

20 UNDERTAKER George L. Rueth ADDRESS 1735 Harford Ave

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

47780

E 47780

CERTIFICATE OF DEATH

129

E 47780

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 2405 Ashland Avenue ST., 7-12 WARD)

2—FULL NAME Marie Catherine Roth

(a) RESIDENCE NO. 2405 Ashland Avenue ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 47 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: John Roth

6 DATE OF BIRTH (month, day, and year): January, 10" 1869

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	60	6	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife 037

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer: At Home

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Lawrence Jung

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Margaret Kares

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: John Roth

(Address): 2405 Ashland Ave.

15 Filed JUL 21 1929 19 WILSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July, 18" 1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 29, 1929, to July 18, 1929, that I last saw her alive on July 18, 1929 and that death occurred, on the date stated above, at 7.45 P. m.

The CAUSE OF DEATH* was as follows:

acute cardiac dilatation - myocarditis - mitral insufficiency - auricular fibrillation -

(duration) yrs. 7 mos. ds.

CONTRIBUTORY (Secondary) Bronchial asthma - hypertension - chr. nephritis -

(duration) yrs. 7 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical exam - urine exam

(Signed) Louis F. Krumman, M. D.

720, 1929 (Address) 722 North Kenwood Ave.

*State the Disease Causing Death, or In deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Trinity Cemetery

DATE OF BURIAL: July, 22 1929

20 UNDERTAKER: Joseph B. Cook

ADDRESS: 1003 W. Pratt St.

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47781

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47781

47

REGISTERED NO. 3-54

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 2427 Lakeview ave ST.) (WARD)

2—FULL NAME Sarah Fischman

(a) RESIDENCE NO. 2427 Lakeview ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5yrs. 5 mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Harry D.

6 DATE OF BIRTH (month, day, and year) 1896

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	33			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto

PARENTS

10 NAME OF FATHER Philip Friedenberg

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Dena Grossman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant Jack Friedenberg

(Address) 2427 Lakeview ave

15 Filed JUL 21 1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20-1929

17 I HEREBY CERTIFY, That I attended deceased from In extremis, 19 , that I last saw her alive on July 20, 1929 and that death occurred, on the date stated above, at 10 9, m.

The CAUSE OF DEATH* was as follows:

Carcinoma of breast with metastases

about 3

(duration) yrs. mos. ds.

CONTRIBUTORY (Serondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? See record—Dr. J. C. Bloodgood Date of

Was there an autopsy? No

What test confirmed diagnosis? See above

(Signed) Louis Jacobs, M. D.

7/21, 19 29 (Address) 1760 Eutaw Place

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Washington Rd

DATE OF BURIAL July 21 1929

20 UNDERTAKER Sol Levinson & Bro

ADDRESS 1127 E Balto St

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47782

CERTIFICATE OF DEATH

E 47782

1—PLACE OF DEATH

REGISTERED NO. 90

CITY OF BALTIMORE: (No. 6303 Brook Ave ST., Yard 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Rosa F. Belz

(a) RESIDENCE NO. 6303 Brook Ave ST.,

(Usual place of abode) WARD

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) 2/24/1850

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	79	4	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work at home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER John Becker

11 BIRTHPLACE OF FATHER (city or town) (State or country) Württemberg Germany

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (city or town) (State or country)

14 Informant Capt Chas Belz

(Address) 6303 Brook Ave

15 Filed JUL 21 1929 Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19th 1929

17 I HEREBY CERTIFY, That I attended deceased from June 2. 1929 to July 19. 1929.

that I last saw her alive on July 18. 1929

and that death occurred, on the date stated above, at 5:20 P.M.

The CAUSE OF DEATH* was as follows:

Myo-Carditis

(duration) yrs. 2 mos. ds.

CONTRIBUTORY (Secondary) Senility

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Examination

(Signed) Benj. D. Hamburger M. D.

7/20, 1929 (Address) 214 N. Caroline St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL July 22, 1929

20 UNDERTAKER John Ulrich

ADDRESS 2008 Orleans

Important. See instructions on back of certificates.

Spec.-7-17-26—A Co.—200 Blks.

47783

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

37-001

L 47783

REGISTERED NO.

1-PLACE OF DEATH Jenkins Memorial Hospital

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

City of BALTIMORE: (No. 1000 Caton Ave St. 7-5-72 Ward)

2-FULL NAME Rosewell Elizabeth Graves

(a) RESIDENCE NO. Sudbrook Park Balto Co St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 6 ds. (If non-resident give city or town and State) How long in U. S. If of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 Color or Race: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Oct 13 1897

7 AGE Years 31 Months 9 Days 7 IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Nurse

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Sudbrook Park

(State or country) Balto Co Md

PARENTS

10 NAME OF FATHER Rosewell H. Graves

11 BIRTHPLACE OF FATHER (City or town)

(State or country) Virginia

12 MAIDEN NAME OF MOTHER Sophia Wyatt

13 BIRTHPLACE OF MOTHER (city or town)

(State or country) Carolina

14 Informant Jenkins Memorial Hospital

(Address) 1000 Caton Ave

15 Filed JUL 21 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-20-29 19

17 I HEREBY CERTIFY, That I attended deceased from 6-24, 1929, to 7-20, 1929, that I last saw h[illegible] alive on 7-20, 1929, and that death occurred, on the date stated above, at 12:45 A.m.

The CAUSE OF DEATH* was as follows:

Miliary Tuberculosis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Dudley P Bowe, M. D.

7/20, 1929 (Address) St. Agnes Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St Thomas Garrison Int

Date of Burial: July 22 1929

20 UNDERTAKER: Henry H Jenkins & Son

ADDRESS: Oakland Md

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 47784

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 47784

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 435 N. Eden St. (Ward) 109

2-FULL NAME Ida Tabbs

(a) RESIDENCE No. 435 N Eden St ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 30 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: Colored

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): March 10 1873

7 AGE: Years 56 Months 4 Days 8 If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House Work

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Sumerpoint Va

PARENTS

10 NAME OF FATHER: Joseph garner

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: James garner (Address): 435 N Eden St

15 Filed JUL 21 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 18 1929

17 I HEREBY CERTIFY, That I attended deceased from July 9 1929 to July 18 1929.

that I last saw her alive on July 18 1929,

and that death occurred, on the date stated above, at 4 20 a m.

The CAUSE OF DEATH* was as follows:

Carcinoma Pulmonum

(duration) yrs. mos 9 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) , M. D.

7-31 1929 (Address)

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Ashley Cemetery

DATE OF BURIAL: July 21 1929

20 UNDERTAKER: Mitch Davis

ADDRESS: 413 N Eden St

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47785

CERTIFICATE OF DEATH

91-00 E 47785

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE (No. 4011 Dorchester Rd (St.) 21-5 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elizabeth C. Merriken

(a) RESIDENCE NO. 4011 Dorchester Rd (Usual place of abode)

WARD

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Widow

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: James T. Merriken

6 DATE OF BIRTH (month, day, and year): Apr 15 1849.

7 AGE: Years 80 | Months 2 | Days 4 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Retired

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Baltimore Md

PARENTS

10 NAME OF FATHER: William Lee

11 BIRTHPLACE OF FATHER (city or town) (State or country): Baltimore Md

12 MAIDEN NAME OF MOTHER: Elizabeth Husk.

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Chas. L. Merriken

(Address) 2202 Rogers av

15 Filed JUL 21 1929, 19 [illegible] Registrar

C. HUDSON JONES, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 19. 1929.

17 I HEREBY CERTIFY, That I attended deceased from June 17. 1929. to July 19. 1929.

that I last saw her alive on July 19. 1929

and that death occurred, on the date stated above, at 9 P. m.

The CAUSE OF DEATH* was as follows:

Cerebral Endarteritis

(duration) 3 yrs. ~ mos. ~ ds.

CONTRIBUTORY (Secondary) General arteriosclerosis

(duration) 8 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) Gustavus C. Dohme, M. D.

7/30. 1929 (Address) 3014 St. Paul St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Druid Ridge Cem	July 22 1929
20 UNDERTAKER: John O Mitchell & Sons.	ADDRESS: 1900 Eutaw Place

important. See instructions on back of certificates.

3014 St. Paul

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47786

CERTIFICATE OF DEATH

88 E 47786

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Balto City Hospital St. 20-28 Ward)

2-FULL NAME Catherine O'Donoghue

(a) RESIDENCE NO. 2009 W Pratt St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred 4 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced
HUSBAND of (or) WIFE of Thos O'Donoghue

6 DATE OF BIRTH (month, day, and year) unknown 1845

7 AGE Years	Months	Days	IF LESS than 1 day ...hrs. or ...min.
about 44			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work House work
(b) General nature of industry, business, or establishment in which employed (or employer) at home
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Maryland

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Unknown

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Unknown

14 Informant Edmund O'Donoghue
(Address) 3630 Gaither Rd Catonsville

15 Filed JUL 22 1929 19 [illegible] Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Investigation (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Investigation (Inquest, autopsy or inquiry) find that said deceased came to [illegible] death on the day stated above.

The CAUSE OF DEATH* was as follows:

Acute Myocarditis

(duration) yrs. mos. 8 ds.

CONTRIBUTORY (Secondary) unknown

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? unknown

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) James M Fenton, M. D.

7/20, 1929 (Address) 700 E Chase St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross Cem.

DATE OF BURIAL July 22 19 29

20 UNDERTAKER Harry J. Wilke 531 N

ADDRESS Lombard

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47787 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47787

CERTIFICATE OF DEATH

99-002

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 8-17 (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Elmer Babcock

(a) RESIDENCE NO. 1606 E. Oliver ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	

a If married, widowed, or divorced HUSBAND of (or) WIFE of unknown

6 DATE OF BIRTH (month, day, and year) 1870

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	59			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Paper Colorer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Unknown

9 BIRTHPLACE (city or town) (State or country) N. Y.

PARENTS

10 NAME OF FATHER (1st name) (Last name) Unknown Babcock

11 BIRTHPLACE OF FATHER (city or town) (State or country) N. Y.

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Unknown

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUL 22 1929 19 G. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21-1929

17 I HEREBY CERTIFY, That I attended deceased from July 14 . 1929 . to July 21 . 1929 . that I last saw him alive on July 21 . 1929 and that death occurred, on the date stated above, at 5 15 A m.

The CAUSE OF DEATH* was as follows:

Myocardial failure - Emphysema + Obesity -

(duration) ? 5 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? yes -

What test confirmed diagnosis? Autopsy.

(Signed) James Bordley Jr. M. D.

7-21 . 1929 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Johnsonburg. Pa	July 22 19 29
(Undertaker) William F. Schaffer	ADDRESS 1816 Monument

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47788

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47788

CERTIFICATE OF DEATH

38

1—PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO. 22-30

CITY OF BALTIMORE: (No. ..... STREET ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Ballard

(a) RESIDENCE NO. 623 S. Sharp ST., ... WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Separated

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	41 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Washington, D.C.

PARENTS

10 NAME OF FATHER Henry Martin ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Maria ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) ? Maryland

14 Informant Records of

(Address) Baltimore City Hospitals

15 Filed JUL 22 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1929 to July 18, 1929, that I last saw h er alive on July 18, 1929 and that death occurred, on the date stated above, at 4:55 P m.

The CAUSE OF DEATH* was as follows:

Syphilis

" Aortic aneurysm

Pyonephritis, bilat. (un-determined)

(duration) ? yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) —

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? P.E.; Lab.; Autopsy

(Signed) Harvey M McLean, M. D.

7-21, 1929 (Address) Baltimore City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn	July 23 1929
20 UNDERTAKER John H. Toadvine	ADDRESS 1027 Hanover

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

22 E 47789 — E 47789

139

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 11-24 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Florence Corkran

(a) RESIDENCE NO. 1129 McCulloh ST., WARD
(Usual place of abode)
(If non-resident give city or town and State)

Length of residence in city or town where death occurred X yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
female	black	married

a If married, widowed, or divorced HUSBAND of (or) WIFE of William Corkran

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work unknown

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md

PARENTS

10 NAME OF FATHER Philip Jenkins

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Jennie Hall

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Records

(Address) Johns Hopkins Hospital

15 Filed JUL 22 1929, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 19-1929

17 I HEREBY CERTIFY, That I attended deceased from July 17, 1929, to July 19, 1929, that I last saw h.r alive on July 19, 1929, and that death occurred, on the date stated above, at 1 p m.

The CAUSE OF DEATH* was as follows:

Myomata uteri
Cardiac failure
operation shock.

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 19th 29

Was there an autopsy? Yes

What test confirmed diagnosis? autopsy.

(Signed) T. Gordon Douglas M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Forest Cemetery — DATE OF BURIAL 7/22/1929

20 UNDERTAKER Mrs. Geo. H. Holland — ADDRESS 631 Druid Hill

important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 47790 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47790

CERTIFICATE OF DEATH.

1-PLACE OF DEATH West Baltimore General. REGISTERED NO.

CITY OF BALTIMORE: (No. 6 ST. WARD) (If death occurred in a hospital or institution, give its NAME instead of street and number.

2-FULL NAME Mr. John Horwitz.

(a) RESIDENCE No. 408 N. Collington Ave WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 35 yrs. mos. ds. How long in U. S., if of foreign birth? 35 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Dora Horwitz

6 DATE OF BIRTH (month, day, and year)

7 AGE: Years 54 Months — Days — If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Plumber.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Russia

PARENTS

10 NAME OF FATHER: Lazer Horwitz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Russia

12 MAIDEN NAME OF MOTHER: Minnie —

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Russia

14 Informant: Dora Horwitz (Address) 408 N. Collington Ave

15 FILED 22 1929 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 21, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 20, 1929. to July 21, 1929.

that I last saw him alive on July 21, 1929

and that death occurred, on the date stated above, at 4:55 A.M.

The CAUSE OF DEATH* was as follows:

Bronchio Pneumonia

(duration) yrs. mos 7 ds.

CONTRIBUTORY (Secondary) Chronic Nephritis

(duration) 1 yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Calogna, M. D.

July 22 1929 (Address) West Balto. General

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Lehren Mem. Park DATE OF BURIAL: July 23 1929

20 UNDERTAKER: Jack Lewis ADDRESS: 1439 E Balto

TION is very important See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Hks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47791

CERTIFICATE OF DEATH

E 47791

REGISTERED NO. 15-65

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 4132 Norfolk ave ST.) (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Sarah Asreal

(a) RESIDENCE NO. 4132 Norfolk ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if foreign birth 74 yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	white	widow

a If married, widowed, or divorced HUSBAND of (or) WIFE of Samuel Asreal

6 DATE OF BIRTH (month, day, and year) 1855

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	74	—	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Russia

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country) Russia

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Russia

14 Informant Paul Asreal

(Address) 4132 Norfolk ave

15 Filed 7-22-1929 C. HERMAN JONES, M.D. Registrar

Par

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21-29

17

I HEREBY CERTIFY, That I attended deceased from July 20, 1929, to July 21, 1929, that I last saw h alive on July 21 1929 and that death occurred, on the date stated above, at 1.40 P m.

The CAUSE OF DEATH* was as follows:

Carcinoma of kidney + metastasis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Terminal hypostatic congestion

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death? at home

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? X Ray Talpon & Tumors

(Signed) Joseph Erlichman, M. D.

July 21 1929 (Address) 326 Garrison Blvd

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Hebrew Hebrew Rum DATE OF BURIAL July 22 19 29

20 UNDERTAKER Jack Lewis ADDRESS 1439 E. Balto St

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47792 HEALTH DEPARTMENT—CITY OF BALTIMORE 46 **E 47792**

CERTIFICATE OF DEATH

1—PLACE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No.) 1247 E. Eager ST. 10-15 WARD)

2—FULL NAME Mamie M. Myers

(a) RESIDENCE NO. 1247 E. Eager ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widowed

3a If married, widowed, or divorced HUSBAND of (or) WIFE of Geo. Myers

6 DATE OF BIRTH (month, day, and year) Dec. 14/1876

7 AGE Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
52	7	3	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Wash. D. C.

PARENTS

10 NAME OF FATHER Robert L. Miller

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ga.

12 MAIDEN NAME OF MOTHER Catherine Kitten

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Wash D.C.

14 Informant Mrs Mary E. Rollins

(Address) 1247 E. Eager

15 Filed ..... 19 ..... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 29/29

17 I HEREBY CERTIFY, That I attended deceased from May 1st, 1929, to July 29th, 1929, that I last saw h E alive on July 29th 1929 and that death occurred, on the date stated above, at 12 45 a.m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Herman Grems, M. D.

July 30 1929 (Address) 1400 Eastern Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Loudon P.K. Cem	July 23 1929
20 UNDERTAKER Philip Haurig	ADDRESS 2116 Eutaw St

Important. See instructions on back of certificates.

JUL 29 1929 HAMPSON JONES, M. D. Registrar

Spec.—1-10-21—M&T—1500 Bks.

E 47793

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

38 E 47793

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Sinai Hospital ST.) 10-14 (WARD)

2-FULL NAME Mr. Henry Moerschel

(a) RESIDENCE No. 706 E. Biddle ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 45 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Anna Moerschel

6 DATE OF BIRTH (month, day, and year) June 24/69

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	60	0	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Baker

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Geo. Moerschel

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ger.

12 MAIDEN NAME OF MOTHER Caroline

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ger.

14 Informant Geo. Moerschel (Address) 2840 Pelham Ave.

15 Filed , 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21, 1929

17

I HEREBY CERTIFY, That I attended deceased from 6-18, 1929, to 7-21, 1929.

that I last saw him alive on 7-21, 1929,

and that death occurred, on the date stated above, at 2:50 A. m.

The CAUSE OF DEATH* was as follows:

Pyelonephritis, bilateral

(duration) yrs mos 27 ds.

CONTRIBUTORY (Secondary) Benign Prostatic Hypertrophy + Syphilis (duration) unknown yrs. mos. ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? ~~supra pubic catheter~~ Yes Date of 7-9-29

Was there an autopsy? Yes

What test confirmed diagnosis? Clinical + Laboratory

(Signed) Benj H Klotz, M. D.

, 19 (Address) Sinai Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn

DATE OF BURIAL 7/23, 1929

20 UNDERTAKER Philip Herwig

ADDRESS 2016 Orleans

Spec.—2-29-28—L. F. S.—500 Bks.

E 47794

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47794

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., WARD)

REGISTERED NO. 712

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Catherine Rasch

(a) RESIDENCE NO. 920 N. Duncan ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 24 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female | 4 COLOR OR RACE: white | 5 Single, Married, Widowed, or Divorced, (write the word): married

6a If married, widowed, or divorced ~~HUSBAND~~ of (or) WIFE of: Adolph

6 DATE OF BIRTH (month, day, and year): 1/17/54

7 AGE — Years: 75 | Months: 6 | Days: 4 | If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer): unknown

(c) Name of employer: unknown

9 BIRTHPLACE (city or town) (State or country): md.

PARENTS

10 NAME OF FATHER: Andrew Kimber

11 BIRTHPLACE OF FATHER (city or town) (State or country): unknown

12 MAIDEN NAME OF MOTHER: unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): unknown

14 Informant: Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..., 19 ... HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7/21/29

17 I HEREBY CERTIFY, That I attended deceased from July 4, 1929, to July 21, 1929, that I last saw her alive on July 21, 1929, and that death occurred, on the date stated above, at 9:20 a.m.

The CAUSE OF DEATH* was as follows:

Acute cardiac dilatation

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) none

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 11, 1929

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Howard C. Knapp, M. D.

, 19 (Address) Johns Hopkins Hosp

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto. Cem.

DATE OF BURIAL: 7/23 1929

20 UNDERTAKER: Philip Herwig

ADDRESS 2016 Orleans

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47795 E 47795

CERTIFICATE OF DEATH

117

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 11 Josephs Hospital ST. 7-12 WARD) REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Frank Borchers

(a) RESIDENCE NO. 631 N. Belnord ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 44 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of ~~(or) WIFE of~~ Amelia Borchers

6 DATE OF BIRTH (month, day, and year) Feb 1/84

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ....min.
	45	5	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Oak Maker

(b) General nature of industry, business, or establishment in which employed (or employer) Lithographing

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Md.

PARENTS

10 NAME OF FATHER August Borchers

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Josephie Hoffman

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Amelia Borchers

(Address) 631 N. Belnord ave

15 Filed ....., 19.. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/21/29.

17 I HEREBY CERTIFY, That I attended deceased from 7/10/29, 19.., to 7/21/29, 19.., that I last saw h... alive on 7/21/29, 19.., and that death occurred, on the date stated above, at 1.00 P m.

The CAUSE OF DEATH* was as follows:

1 Mr pneumonia appendicitis with peritonitis

CONTRIBUTORY (Secondary) Tuberculosis (duration) yrs. mos. 18 ds.

18 Where was disease contracted if not at place of death? Home (duration) yrs. mos. 5 ds.

Did an operation precede death? Yes Date of 7/16/29

Was there an autopsy? No

What test confirmed diagnosis? Operation

(Signed) H B Hundley, M. D.

19 (Address) St Joseph Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Oak Lawn

DATE OF BURIAL 7/24 19 29

20 UNDERTAKER Philip Hornig

ADDRESS 2016 Orleans

Important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 47796

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

29 E 47796

1-PLACE OF DEATH Woman's Hospital

CITY OF BALTIMORE: (No. ..... ST. 10-14 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Matilda Lautenschlager

(a) RESIDENCE NO. 1124 Ensor St. ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred Life mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	married

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of C. Lautruschlager

6 DATE OF BIRTH (month, day, and year) April 26, 1886.

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	43	2	24	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer) ✓

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md.

PARENTS

10 NAME OF FATHER Charles Wittich

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore, Md.

12 MAIDEN NAME OF MOTHER Elizabeth Loos

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore, Md.

14 Informant C. Lautruschlager
(Address) 1124 Ensor St.

15 Filed ..... 19 .....

C. HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 1929.

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1929, to July 20, 1929, that I last saw her alive on July 20, 1929, and that death occurred, on the date stated above, at 12:24 P. m.

The CAUSE OF DEATH* was as follows:

Cardio-vascular renal disease.

(duration) ✓ yrs. mos ds.

CONTRIBUTORY (Secondary) Uremia

(duration) — yrs. — mos. 2 ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of ✓

Was there an autopsy? Yes

What test confirmed diagnosis? Laboratory.

(Signed) Earle P. Clemson, M. D.

July 20, 1929 (Address) Woman's Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Baltimore Cemetery — DATE OF BURIAL July 23rd 1929

20 UNDERTAKER Henry Koch Sons Inc. — ADDRESS 1301 E Eager St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47797

CERTIFICATE OF DEATH

E 47797

129

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1506 Linden Av ST. 11-20 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Dr Howard - Miller Houck

(a) RESIDENCE NO. 1506 Linden Av ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 58 yrs. 11 mos. 10 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Kathryn Houck

6 DATE OF BIRTH (month, day, and year) Aug 10 1871

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	58	11	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Doctor

(b) General nature of industry, business, or establishment in which employed (or employer) Dr

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER John F. Houck

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Eliz Graham

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Kathryn Houck

(Address) 1506 Linden Ave

15 Filed ..., 19 ... Registrar

C. HAMILTON COOMBS, M.D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7 - 20th 1929

17

I HEREBY CERTIFY, That I attended deceased from June 30, 1929, to July 20, 1929, that I last saw h... alive on July 20, 1929 and that death occurred, on the date stated above, at 11.02 A. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) 2 yrs. — mos. — ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. 5 mos. 21 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) H. C. Patterson, M. D.

, 19 (Address) 812 Hamilton Ter

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Angel Hill Cem Havre de Grace Md	7-22 1929
20 UNDERTAKER	ADDRESS
James Cunningham & Son	Havre de Grace Md

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47798 HEALTH DEPARTMENT—CITY OF BALTIMORE **E 47798**

CERTIFICATE OF DEATH

3 1

1—PLACE OF DEATH

REGISTERED NO.

CITY OF BALTIMORE: (No. 230 S. Washington ST., 2 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary H. Dougherty

(a) RESIDENCE NO. 230 S. Washington ST., 2 WARD
(Usual place of abode)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

a If married, widowed, or divorced HUSBAND of (or) WIFE of the late Michael Dougherty

6 DATE OF BIRTH (month, day, and year) Sept. 26 1859

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
69	9	20	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Conrad Minderlein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Veronica Minderlein

(Address) 230 S. Washington St.

15 Filed 7 22 1929, 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20th/29

17 I HEREBY CERTIFY, That I attended deceased from July 16, 1928, to July 20, 1929, that I last saw h[illegible] alive on [illegible] 19 and that death occurred, on the date stated above, at 11 40 P. m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

Died

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis

Died

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? Physical signs

(Signed) Jos. Keller, M. D.

7. 21. 29 (Address) 1937 Gough St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer Cem. DATE OF BURIAL July 23 1929

20 UNDERTAKER Lilly & Julia Sue ADDRESS 4033 Wolfe St

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47799

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47799

CERTIFICATE OF DEATH

100-0

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 526 N. Gilmor ST. 19-27 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Carrie Houston

(a) RESIDENCE NO. 526 Gilmore ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Single.

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Jan 5. 1929

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
		6	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Infant.

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Balto (State or country) md.

PARENTS

10 NAME OF FATHER Dan Houston.

11 BIRTHPLACE OF FATHER (city or town) (State or country) S. C.

12 MAIDEN NAME OF MOTHER Caroline Cook.

13 BIRTHPLACE OF MOTHER (city or town) (State or country) S. C.

14 Informant Caroline Houston

(Address) 526 N. Gilmore St

15 Filed ..... 19 .....

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 1929

17 I HEREBY CERTIFY, That I attended deceased from July 18, 1929, to July 20, 1929, that I last saw h[illegible] alive on July 19, 1929 and that death occurred, on the date stated above, at 2 A m.

The CAUSE OF DEATH* was as follows:

Postal Pneumonia

(duration) yrs. mos. 2 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) D. H. Hatcher, M. D.

7/22, 1929 (Address) 1115 Pe Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cemetery	July 22 1929
20 UNDERTAKER Thomas E. Kelson.	ADDRESS 1303 Pressman St

JUL 22 1929 C. HAMPSON JONES, M. D. Registrar

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47800 — **CERTIFICATE OF DEATH** — **E 47800**

REGISTERED NO. 31

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1952 N. Day st ST. 8-16 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mrs. Mildred H. Velsor

(a) RESIDENCE NO. 1952 N. Day ST., WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 23 yrs. 2 mos. 10 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced (or) ~~HUSBAND of~~ WIFE of Wilbur J. Velsor

6 DATE OF BIRTH (month, day, and year) May 10-1906

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	23	2	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work House Work

(b) General nature of industry, business, or establishment in which employed (or employer) 037

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John St. Montesh

11 BIRTHPLACE OF FATHER (city or town) (State or country) Baltimore Md

12 MAIDEN NAME OF MOTHER Lola Martin

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Baltimore Md

14 Informant Mrs. Lillian Stark

(Address) 1952 N. Baker Road

Filed JUL 22 1929 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20, 1929

17 I HEREBY CERTIFY, That I attended deceased from April 17, 1929, to July 20, 1929, that I last saw her alive on July 19, 1929 and that death occurred, on the date stated above, at 1004 A m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis

(duration) yrs. 8 mos. 15 ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? None

(Signed) C. F. O'Donnell, M. D.

7/21, 1929 (Address) 9 E Biddle St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Woodlawn Cemetery	July 23 1929

20 UNDERTAKER Henry Lutz ADDRESS 1203 E. Broadway

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47801 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47801

1—PLACE OF DEATH Union Memorial Hospital

REGISTERED NO. 129

CITY OF BALTIMORE: (No. ..... ST. 12-49 ..... WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Harold H. Wells

(a) RESIDENCE NO. Belair, Md ST., ... WARD

(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 14 ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) Dec. 11, 1910

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ..... min.
	18	7	11	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Student

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Washington, Maryland.

PARENTS

10 NAME OF FATHER James M. Wells

11 BIRTHPLACE OF FATHER (city or town) (State or country) Maryland

12 MAIDEN NAME OF MOTHER Amelia Zugler

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Maryland

14

Informant Mrs. J. M. Wells

(Address) Belair, Maryland.

15

Filed ..... 19 ..... C. HAMPSON JONES, M. D.

Registrar

22102

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22, 1929.

17

I HEREBY CERTIFY, That I attended deceased from July 7, 1929, to July 22, 1929, that I last saw h[illegible] alive on July 22, 1929 and that death occurred, on the date stated above, at 8:07 A. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial nephritis

(duration) Indefinite yrs. ..... mos. ..... ds.

CONTRIBUTORY (Secondary) .....

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? .....

Did an operation precede death? No Date of .....

Was there an autopsy? No.

What test confirmed diagnosis? Laboratory and Path.

(Signed) Francis W. Luck, M. D.

, 19 (Address) Union Memorial Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Zion Cemetery	July 25 1929
20 UNDERTAKER Deans & Foster	ADDRESS Belair Md

Important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 47802

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47802

1-PLACE OF DEATH West Baltimore General 129

CITY OF BALTIMORE: (No. 20-C ST. WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mrs. Anna L. Andrews.

(a) RESIDENCE No. 2600 Frederick Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 72 yrs. — mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced (write the word): Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: David Andrews

6 DATE OF BIRTH (month, day, and year): July 7, 1857

7 AGE: Years 72 Months — Days 15 If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore, Md.

PARENTS

10 NAME OF FATHER: Phillip Forney

11 BIRTHPLACE OF FATHER (city or town) (State or country): California

12 MAIDEN NAME OF MOTHER: Margaret Hayes

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md.

14 Informant: P. Stanley Andrews

(Address)

JUL 22 1929

C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 22, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 5, 1929, to July 22 1929, that I last saw h— alive on July 22 1929 and that death occurred, on the date stated above, at 2:30 a. m.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage & Hemiplegia (Hypertensive).

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Chronic Nephritis.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) H. Hodges, M. D.

(Address) West Balto. Tunnel.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: London Park — DATE OF BURIAL 19

20 UNDERTAKER: Geo W Little — ADDRESS

TION is very important See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 47803 HEALTH DEPARTMENT—CITY OF BALTIMORE E 47803

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of Baltimore: (No. 532 N. Monroe St. W-27 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Ida B. Cochran.

(a) RESIDENCE NO. 532 N Monroe St. Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male | 4 Color or Race: White | 5 Single, Married, Widowed or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Adam E

6 DATE OF BIRTH (month, day, and year): May 12 1866

7 AGE: Years 62 | Months 11 | Days 9 | IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Clerk.
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town): Md.
(State or country)

PARENTS

10 NAME OF FATHER: Andrew Cochran

11 BIRTHPLACE OF FATHER (city or town): Scotland
(State or country)

12 MAIDEN NAME OF MOTHER: Isabella Watson

13 BIRTHPLACE OF MOTHER (city or town): Ireland
(State or country)

14 Informant: Ada E Cochran
(Address): 532 N Monroe

15 Filed JUL 22 1929 C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 21 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Chronic Myocarditis

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) A. Pugsley M. D.

July 21 (Address) Coroner

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Balto Cemetery | DATE OF BURIAL: July 24 1929

20 UNDERTAKER: Jno B Spencer | ADDRESS: 1328 N Caroline St

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47804 HEALTH DEPARTMENT—CITY OF BALTIMORE **E 47804**

CERTIFICATE OF DEATH

24-001

REGISTERED NO. 27-43

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 6618 Belfad Ave WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James W Hammack

(a) RESIDENCE NO. 6618 Belfad Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 5yrs mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 ~~Single, Married~~, Widowed, ~~or Divorced~~ (write the word)
Male	white	widower

6a If married, widowed, or divorced HUSBAND of (or ~~WIFE of~~) Jennie Hammack.

6 DATE OF BIRTH (month, day, and year) May 29, 1853

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	76	11	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Baltimore, Md

PARENTS

10 NAME OF FATHER Don't Know

11 BIRTHPLACE OF FATHER (city or town) (State or country) Don't Know

12 MAIDEN NAME OF MOTHER Don't Know

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Don't Know

14 Informant Martin J. Hedland

(Address) 6618 Belfad Ave

15 Filed JUL 22 1929 HAMPSON JONES, Registrar

important. See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 5, 1929 to July 20, 1929

that I last saw h alive on July 20, 1929

and that death occurred, on the date stated above, at 6.05 p m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral hemorrhage

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical signs

(Signed) Chas H Threet M. D.

7/21, 1929 (Address) Maple Ave & Belair Rd.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Baltimore Cemetery

DATE OF BURIAL July 23 1929

20 UNDERTAKER Robt I Turner

ADDRESS 1442 N Broadway

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47805

CERTIFICATE OF DEATH

E 47805

1—PLACE OF DEATH

REGISTERED NO. 101-001

CITY OF BALTIMORE: (No. 904 McElderry St., WARD) 12

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Julia Flemmings

(a) RESIDENCE NO. 904 McElderry St. WARD

(Usual place of abode)

(If non-resident give city or town and State)

Length of residence in city or town where death occurred 1 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: F.

4 COLOR OR RACE: C.

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Sept 13, 1915

7 AGE: Years 13 | Months 10 | Days 6 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DEASED

(a) Trade, profession or particular kind of work: School Girl

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Balto. Md.

PARENTS

10 NAME OF FATHER: Floyd Mills

11 BIRTHPLACE OF FATHER (city or town) (State or country): Balto. Md.

12 MAIDEN NAME OF MOTHER: Julia Flemmings

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto. Md.

14 Informant: Julia Mills

(Address) 904 McElderry St.

15 Filed L 27 1929 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 19-29

17 I HEREBY CERTIFY, That I attended deceased from July 10, 1929, to July 19, 1929, that I last saw h[illegible] alive on July 19, 1929 and that death occurred, on the date stated above, at 2 00 m.

The CAUSE OF DEATH* was as follows:

Tuberculosis Pulmonalis

(duration) 9 yrs. mos. ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? No

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) Geo. L. D. Allen, M. D.

7-22, 1929 (Address) 1515 Lemmon St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt. Calvary Cem.	July 22, 1929
20 UNDERTAKER: Thos. R. G. Elliott	ADDRESS 1725 Ashland Ave

important. See instructions on back of certificates.

Spec.—12-9-25—A Co.—200 Bks.

Martha Brooks ✓

E 47806

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

31 E 47806

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

City of BALTIMORE: (No. 507 Mosher St. 14-20 Ward)

2-FULL NAME Martha Brooks

(a) RESIDENCE NO. 507 Mosher St. Ward

(Usual place of abode)

Length of residence in city or town where death occurred fifty yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: female

4 Color or Race: Colored

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Oct 9 1909

7 AGE: Years 19 | Months 9 | Days 13 | IF LESS than 1 day ....hrs. or ....min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Domestic

(b) General nature of industry, business, or establishment in which employed (or employer): do

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore

(State or country) Md

10 NAME OF FATHER Harry Brooks

11 BIRTHPLACE OF FATHER (city or town) St Mary Co Md

(State or country)

12 MAIDEN NAME OF MOTHER Harriet Robinson

13 BIRTHPLACE OF MOTHER (city or town) Balto

(State or country) Md

PARENTS

14 Informant Mrs Mary Brooks.

(Address) 507 Mosher St

15 Filed C. HAMPSON JONES, M. D. Registrar

Per

22 1929

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22 1929

17 I HEREBY CERTIFY, That I attended deceased from Dec. 14 1929, to July 22, 1929 that I last saw h alive on July 20, 1929 and that death occurred, on the date stated above, at 1:30 a.m.

The CAUSE OF DEATH* was as follows:

Femoral Embolism about 10 d

CONTRIBUTORY (Secondary) Pulmonary Tuberculosis (duration) 2 yrs. 8 mos. 7 ds.

18 Where was disease contracted

If not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) John H. Simpson, M. D.

19 (Address) 1012 W Fayette

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Calvary Date of Burial July 26, 1929

20 UNDERTAKER: Wm. R. A. Elliott ADDRESS 1325 Washington

For sought be carefully supplied. Any answer not known should be stated. Prepare and type or write plainly. Cause of death must be stated in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47807

CERTIFICATE OF DEATH.

E 47807

117

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Provident Hospital ST., 17-24 WARD)

2-FULL NAME John H Anderson

(a) RESIDENCE NO. 908 D. Hill Av ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Male	col	Married

5a If married, widowed, or divorced HUSBAND of (or) ~~WIFE~~ of Daisey Anderson

6 DATE OF BIRTH (month, day, and year) April 15 1894

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min
	35	3	6	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto. Md

PARENTS

10 NAME OF FATHER Peter Anderson

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Mary Bruce

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md.

14 Informant Daisey Anderson

(Address) 908 D Hill Ave.

15 Filed ..... 19 C. HAMPSON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-21-1929

17 I HEREBY CERTIFY, That I attended deceased from 7-19, 1929, to 7-21, 1929, that I last saw him alive on 7-21, 1929 and that death occurred, on the date stated above, at 12.30 a.m.

The CAUSE OF DEATH* was as follows:

Gangrene appendix rupture

Stercoral fecal fistula

(duration) yrs. mos. 5 ds.

CONTRIBUTORY (Secondary) Intestinal obstruction

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? yes Date of 7/17/29

Was there an autopsy? yes

What test confirmed diagnosis? Autopsy

(Signed) T. F. Jackson M. D.

7/21 1929 (Address) 600 Harlington Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Auburn Cemetery — DATE OF BURIAL July 24 1929

20 UNDERTAKER Mrs. P. G. Elliott — ADDRESS 1525 Ashland Ave

CAUSE OF DEATH in plain terms, so that it may be properly classified. TION is very important See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

227 41

E 47808

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

X 41

E 47808

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST., 7-4 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Hammond

(a) RESIDENCE NO. 1335 Hillen Rd ST., WARD Towson Md

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. 9 ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	black	single

3a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) December 3 1904

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	25	4	12	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer unknown

9 BIRTHPLACE (city or town) (State or country) Md

10 NAME OF FATHER George Hill

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md

12 MAIDEN NAME OF MOTHER Sophie Hammond

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

PARENTS

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed ..... 19 .....

C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20th 1929

17 I HEREBY CERTIFY, That I attended deceased from July 11, 1929 to July 20, 1929 that I last saw him alive on July 20, 1929 and that death occurred, on the date stated above, at 6 45 a m.

The CAUSE OF DEATH* was as follows:

Streptococcus Septicaemia

(duration) yrs. 1 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Blood Culture

(Signed) James Bradley III M. D.

7-20, 1929 (Address) Johns Hopkins Hospital.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Pleasant Rest Cemty

DATE OF BURIAL July 23 1929

20 UNDERTAKER Mrs R. G. Elliott

ADDRESS 725 Ashland Ave

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47809

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47809

REGISTERED NO. 31

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1114 W Franklin St., 18th WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Myrtle Holmes

(a) RESIDENCE NO. 1114 W Franklin ST. WARD
(Usual place of abode)

Length of residence in city or town where death occurred 5 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Col	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	24			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Va

PARENTS

10 NAME OF FATHER W. T. Louis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Va

12 MAIDEN NAME OF MOTHER Susan Logan

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Va.

14 Informant Eula Taylor

(Address) 1114 W Franklin St.

15 Filed JUL 22 1929 [illegible] Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 '29

17 I HEREBY CERTIFY, That I attended deceased from March 15, 1929, to July 20, 1929, that I last saw h alive on July 7 20, 1929 and that death occurred, on the date stated above, at 3 P m.

The CAUSE OF DEATH* was as follows:

Intussusception of Intestines

(duration) yrs. 6 mos. ds.

CONTRIBUTORY (Secondary) Nephritis

(duration) yrs. 1 mos. ds.

18 Where was disease contracted if not at place of death? 15 N. Mount St.

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Symptoms

(Signed) Wilbur [illegible] M. D.

7/20, 1929 (Address) 1428 Pennsylvania Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Irvington Va

DATE OF BURIAL 7-22 1929

20 UNDERTAKER Daniel Easton

ADDRESS 916 Pa Ave

important. See instructions on back of certificates.

Spec.—I-10-21—M&T—1500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47810 E 47810

CERTIFICATE OF DEATH.

154-007

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1107 N. Monroe St. 16-22 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Charles Lewis Keefer

(a) RESIDENCE NO. 1107 N. Monroe ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred — yrs. 1 mos. — ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year) 6-21-29.

7 AGE

Years	Months	Days	If LESS than 1 day, hrs. or min.
—	1	—	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto City

PARENTS

10 NAME OF FATHER Vance C. Keefer

11 BIRTHPLACE OF FATHER (city or town) (State or country) Carrol Co. Md.

12 MAIDEN NAME OF MOTHER Nora E. Mentzer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Carrol Co Md

14 Informant Mrs Nora E Keefer

(Address) 1107 N. Monroe St

15 Date JUL 22 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-21 1929

17 I HEREBY CERTIFY, That I attended deceased from 6-21 , 1929, to 7-21 , 1929, that I last saw him alive on 7-20 , 1929 and that death occurred, on the date stated above, at 9.45 A m.

The CAUSE OF DEATH* was as follows:

Congenital Cardiac Malformation

(duration) — yrs. 1 mos — ds.

CONTRIBUTORY (Secondary) None

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? — —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Chas. C. Conser, M. D.

7-22, 1929 (Address) 113 N. Fulton Ave.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cedar Hill Cem DATE OF BURIAL 7/22/1929

20 UNDERTAKER J. J. Paley & Son ADDRESS 318 Light

MAJOR should be careful, legible, and CERTAIN. Exact statement of OCCUPATION is very important. See instructions on back of certificates. CAUSE OF DEATH in plain terms, so that it may be properly classified.

Spec.—1-10-21—M&T—1500 Bks.

William Roberts ✓

E 47811 HEALTH DEPARTMENT—CITY OF BALTIMORE **E 47811**

CERTIFICATE OF DEATH.

7 + 100-01

1-PLACE OF DEATH U.S. Marine Hospital.

CITY OF BALTIMORE: (No.) Baltimore, Maryland (ST.) 12-51 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME William Roberts

(a) RESIDENCE NO. 25 South Street, New York ST., ... WARD .....

(Usual place of abode)

Length of residence in city or town where death occurred yrs. 2 mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 25, 1884

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	45	2	15 25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Merchant Seaman

(b) General nature of industry, business, or establishment in which employed (or employer): Boatswain

(c) Name of employer: S/S "Mitchell" Phila.

9 BIRTHPLACE (city or town) (State or country): Manchester, N.H.

PARENTS

10 NAME OF FATHER: Eugene Roberts

11 BIRTHPLACE OF FATHER (city or town) (State or country): Manchester, N.H.

12 MAIDEN NAME OF MOTHER: Matilda ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Manchester, N.H.

14 Informant (Address): Clinical Records U.S. Marine Hospital, Baltimore, Md.

15 JUL 22 1929 C. HAMPSON JONES, M. D. Registrar

Per

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 19 29

17 I HEREBY CERTIFY, That I attended deceased from June 8 19 29, to July 20 19 29,

that I last saw him alive on July 19 19 29,

and that death occurred, on the date stated above, at 12:00 a. m.

The CAUSE OF DEATH* was as follows:

Pneumonia, broncho

(duration) yrs. 1 mos 15 ds.

CONTRIBUTORY (Secondary) Secondary, abscess of lungs

(duration) yrs. mos. 8 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? Yes

What test confirmed diagnosis? Autopsy clinical & laboratory findings

(Signed) Ralph L. Pollet M. D.

19 (Address) U.S. Marine Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: St. Mary's, Hamden — DATE OF BURIAL: July 22, 1929

20 UNDERTAKER: E. Leroy Stiffler & Inc. — ADDRESS: 125 E. North Ave.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

29 E 833 47812

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

74-001 E 47812

1—PLACE OF DEATH

JOHNS HOPKINS HOSPITAL

CITY OF BALTIMORE: (No. ..... ST., 7-9 WARD)

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Amy P. Newman

(a) RESIDENCE NO. Upper College Terrace WARD Frederick Md.
(Usual place of abode)

Length of residence in city or town where death occurred ..... yrs. ..... mos. 22 ds. How long in U. S., if foreign birth? ..... yrs. ..... mos. ..... ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Judge John S—

6 DATE OF BIRTH (month, day, and year): 2/13/71

7 AGE — Years: 57 — Months: 3 — Days: 9 — If LESS than 1 day, hrs. or min.:

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: House wife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Md—

PARENTS

10 NAME OF FATHER: Wash. Parsons

11 BIRTHPLACE OF FATHER (city or town) (State or country): Md—

12 MAIDEN NAME OF MOTHER: Laura Abbott

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Md

14 Informant: Friends—

(Address) JOHNS HOPKINS HOSPITAL

15 JUL 22 1929 Registrar

C. HARRISON JONES, M. D.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 22-29

17 I HEREBY CERTIFY, That I attended deceased from May 31, 1929, to July 22, 1929, that I last saw h— alive on July 22, 1929, and that death occurred, on the date stated above, at 10 10a m.

The CAUSE OF DEATH* was as follows:

Cholecystitis

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Cerebral hemorrhage.

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes. Date of July 21 29

Was there an autopsy? No.

What test confirmed diagnosis?

(Signed) A. D. Warfield, M. D.

19 (Address) J. H. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Frederick Md — DATE OF BURIAL: July 23 1929

20 UNDERTAKER: C C Canty — ADDRESS: Frederick Md

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Bks.

E 47813

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 47813

129

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1811 E. 30th St. ST. 9-46 (WARD)

2-FULL NAME Catherine Langan

(a) RESIDENCE NO. 1811 E. 30th St ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 74 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female.	White.	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) March 11, 1855

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	74	4	10	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md
(State or country)

PARENTS

10 NAME OF FATHER Tom Langan

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Ireland.

12 MAIDEN NAME OF MOTHER Catherine Gavin.

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Ireland.

14 Informant Mrs. ~~Cecilia~~ Callaghan

(Address) 1811 E. 30th St

35 Filed 7 27 1929 C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 1929

17 I HEREBY CERTIFY, That I attended deceased from June 26, 1929, to July 21, 1929, that I last saw her alive on July 20, 1929, and that death occurred, on the date stated above, at 7.00 a. m.

The CAUSE OF DEATH* was as follows:

Chronic Diffuse Nephritis

(duration) 7 yrs. mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical & Laboratory findings

(Signed) Chas. Wilbur Stewart, M. D.

7/21, 1929 (Address) 1738 E. 28th St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Cathedral Cemetery — DATE OF BURIAL 7/24 1929

20 UNDERTAKER Elias P. Fraunfelter — ADDRESS 1300 Druid Park Drive

Spec.—2-29-28—L. F. S.—600 Bks.

E 47814

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

24-001

E 47814

REGISTERED NO.

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1242 E North Ave 9-18 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Catherine McKittrick

(a) RESIDENCE NO. 1242 E North Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred Lifetime yrs. mos. ds. How long in U. S., If foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) April 23 1853

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	76	2	27	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work None

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Balto Md

PARENTS

10 NAME OF FATHER Charles McKittrick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ireland

12 MAIDEN NAME OF MOTHER Mary McDonald

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant Miss Margaret E Carroll

(Address) 1242 E North Ave

15 Filed JUL 22 1929 Register

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 1929

17 I HEREBY CERTIFY, That I attended deceased from 6-12, 1929, to 7-20, 1929, that I last saw her alive on 7-19, 1929 and that death occurred, on the date stated above, at 7 20 A m.

The CAUSE OF DEATH* was as follows:

Arteriosclerosis

(duration) 1 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis?

(Signed) Edward J Lowe M. D.

7/20 1929 (Address) 413 N Washington

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cathedral Cemetery	7/23 1929
20 UNDERTAKER	ADDRESS
Chas P Carleton	1120 W Fayette Ave

Important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47815

CERTIFICATE OF DEATH

+199 E 47815

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. City Hospitals 26-37 St. Ward)

2-FULL NAME Peter Laitti

(a) RESIDENCE NO. 1600 Frances St. (Usual place of abode) St., Ward

Length of residence in city or town where death occurred yrs. mos. 7 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of None 1899

6 DATE OF BIRTH (month, day, and year) 1899

7 AGE Years	Months	Days	IF LESS than 1 day hrs. or min.
30			

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Shipbuilder
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town) Calumet (State or country) Mich

PARENTS

10 NAME OF FATHER Unknown

11 BIRTHPLACE OF FATHER (city or town) Unknown (State or country)

12 MAIDEN NAME OF MOTHER Eva Latti

13 BIRTHPLACE OF MOTHER (city or town) Unknown (State or country)

14 Informant Hospital Records (Address)

15 Filed ..., 193.. C. HAMPSON JONES, M. D. Registrar

UL 22 1929 Plot.

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day and year) July 18 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquiry (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquiry (Inquest, autopsy or inquiry) and that said deceased came to his death on the day stated above.
The CAUSE OF DEATH was as follows:

Homicide

Fracture of Skull

(duration) 1 yrs. mos. 1 ds.

CONTRIBUTORY (Secondary) Cerebral Hemorrhage

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? — —

Did an operation precede death? — Date of —

Was there an autopsy? Yes

What was confirmed diagnosis? Autopsy

7/29/29 (Signed) Gladis, M. D.

19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Carmel Cemetery — DATE OF BURIAL 7/22 1929

20 UNDERTAKER George J Ruth — ADDRESS 1735 Orford Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-12-23—M&T—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47816

CERTIFICATE OF DEATH.

100,001 ✓ E 47816

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) 1313 Lafayette av (St.) 16-23 (WARD)

REGISTERED NO. .....
(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Sylvester O Smith.

(a) RESIDENCE NO. 1313 Lafayette av ST., ... WARD .....
(Usual place of abode)
Length of residence in city or town where death occurred ..... yrs. ..... mos. ..... ds. How long in U. S., if of foreign birth? ..... yrs. ..... mos. ..... ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
M	C	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ✓

6 DATE OF BIRTH (month, day, and year) June 13. 1829

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
		1	8	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work. Infant

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer ✓

9 BIRTHPLACE (city or town) (State or country) 1313 W Lafayette av

PARENTS

10 NAME OF FATHER Raymond W Smith

11 BIRTHPLACE OF FATHER (city or town) (State or country) Md.

12 MAIDEN NAME OF MOTHER Katherine Bolt

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Md

14 Informant Katherine Smith
(Address) 1313 W Lafayette av.

15 Filed JUL 27 1929 C. HARRISON JONES, M. D. Registrar
Per ....

CAUSE OF DEATH to plain terms, so that it may be properly classified. TION is very important See instructions on back of certificates.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 30 19 29

17 I HEREBY CERTIFY, That I attended deceased from July 19, 19 29, to July 21, 19 29, that I last saw him alive on July 21, 19 29 and that death occurred, on the date stated above, at 11:30 A m.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) ..... yrs. mos 3 ds.

CONTRIBUTORY (Secondary) None

(duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? ✓

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Physical

(Signed) W N Wright, M. D.

19 (Address) 1209 Park Avenue

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
W.S. Anderson	July 22 19 29
20 UNDERTAKER Lemuel A Chase & Son	ADDRESS 1900 Pitcher

Spec.—2-29-28—L. F. S.—500 Bks.

Dr Ferry
910 W Lombard

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47817

CERTIFICATE OF DEATH

29

REGISTERED NO. E 47817

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1301 West Lombard ST. 9-29 WARD)

2—FULL NAME Mary A Cromer

(a) RESIDENCE NO. 1301 West Lombard ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 20 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced (write the word)
Female	White	Widowed

6a If married, widowed, or divorced HUSBAND of (or) WIFE of Daniel J. Cromer

6 DATE OF BIRTH (month, day, and year) April 25, 1841

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	88	2	25	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work At Home

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Virginia

PARENTS

10 NAME OF FATHER Thomas Gilmore

11 BIRTHPLACE OF FATHER (city or town) (State or country) Virginia

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) New Jersey

14 Informant P H Cromer
(Address) 325 West North Ave

15 Filed JUL 22 1929 HARRY R. JONES, M. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20-1929

17 I HEREBY CERTIFY, That I attended deceased from 7/10/29, 19 to 7/20/29, 19

that I last saw h alive on 7/20/29, 19

and that death occurred, on the date stated above, at 10 a.m. p.m.

The CAUSE OF DEATH* was as follows:

Chr Diff Path

(duration) unknown yrs. mos. ds.

CONTRIBUTORY (Secondary) Hypostatic Pneumonia

(duration) yrs. mos. 3 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Date of

Was there an autopsy?

What test confirmed diagnosis? only

(Signed) Edward J Ferry, M. D.

, 19 (Address) 910 W Lombard

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Presbyterian Ground	7/22 1929
20 UNDERTAKER William Cook	ADDRESS 1217 St Paul

Spec.—1-12-23—M&T—500 Blks.

E 47818 HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

E 47818

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 1661 Thomas Ave ST. 15-68 WARD)

2-FULL NAME Mr. John Cook

(a) RESIDENCE NO. 1661 Thomas Ave ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Life yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed or divorced HUSBAND of (or) WIFE of Mary Cook

6 DATE OF BIRTH (month, day, and year) Sept. 16 1859

7 AGE	Years	Months	Days	If LESS than 1 day, hrs or min.
	69	10	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Engineer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Latrobe Light

9 BIRTHPLACE (city or town) Baltimore (State or country) Md

PARENTS

10 NAME OF FATHER Joseph Cook

11 BIRTHPLACE OF FATHER (city or town) (State or country) Ga

12 MAIDEN NAME OF MOTHER Robinson

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Ga

14 Informant Mary Cook

(Address) 1661 Thomas Ave

Filed JUL 22 1929 W. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 1929

17

I HEREBY CERTIFY, That I attended deceased from April 11, 1929, to July 21, 1929, that I last saw him alive on July 20, 1929, and that death occurred, on the date stated above, at 8.30 A m.

The CAUSE OF DEATH* was as follows:

Mitral stenosis, mitral insufficiency

(duration) at least 5 yrs. mos ds.

CONTRIBUTORY (Secondary) Chronic passive congestion

(duration) yrs. mos. 17 ds.

18 Where was disease contracted if not at place of death? not known

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clin. & Labor. methods

(Signed) Paul L. Smith Jr., M. D.

, 19 (Address) 1120 St Paul St Balto.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Mt Olivet

DATE OF BURIAL 7/23 1929

UNDERTAKER William Cook

ADDRESS 1217 St Paul

CAUSE OF DEATH in plain terms, so that it may be used for statistical purposes. See instructions on back of certificates.

Spec.—2-20-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47819 — 1—PLACE OF DEATH

30

E 47819 — REGISTERED NO.

CITY OF BALTIMORE: (No. Baltimore City Hosp. WARD) 22-30

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Josephine Crupi

(a) RESIDENCE NO. 115 W Base ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 16 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Fem	White	Married

5a If married, widowed, or divorced WIFE of (or) HUSBAND of: Michael Crupi

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	53			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housewife

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: Hospital Record

(Address)

15 Date: JUL 22 1929 19

HAMPSON JONES, M. D.
Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7/20/29

17 I HEREBY CERTIFY, That I attended deceased from 3/9, 1929, to 7/20, 1929, that I last saw h er alive on 7/20, 1929 and that death occurred, on the date stated above, at 6 20 P. m.

The CAUSE OF DEATH* was as follows:

Mycosis Fungoides

(duration) yrs. 4 mos. ds.

CONTRIBUTORY (Secondary): Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? Unknown

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? ~~Path Laboratory~~

(Signed) H. H. Thompson, M. D.

7/21, 1929 (Address) Baltimore City Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt Cathedral — DATE OF BURIAL: 7/23 1929

20 UNDERTAKER: H. A. Cook — ADDRESS: 1217 E Fayette St

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Blks.

227290

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47820

E 47820

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. JOHNS HOPKINS HOSPITAL ST. 11-24 WARD)

REGISTERED NO. 129

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John H. Herrick

(a) RESIDENCE NO. Brevton apts Park & Chase ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred Unknown yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Unknown

6a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	67			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Merchant

(b) General nature of industry, business, or establishment in which employed (or employer) Unknown

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) N. Y.

PARENTS

10 NAME OF FATHER John Herrick

11 BIRTHPLACE OF FATHER (city or town) (State or country) Unknown

12 MAIDEN NAME OF MOTHER Lelnie Elmer

13 BIRTHPLACE OF MOTHER (city or town) (State or country) N. Y.

14 Informant Records

(Address) JOHNS HOPKINS HOSPITAL

15 Filed JUL 22 1929 HAMILTON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 - 1929

17 I HEREBY CERTIFY, That I attended deceased from July 17, 1929, to July 21, 1929, that I last saw him alive on July 21, 1929 and that death occurred, on the date stated above, at 7.20 P. m.

The CAUSE OF DEATH* was as follows:

Arteries—sclerosis, chronic myocarditis (Cerebral hemorrhage)

(duration) 10 yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac decompensation

Chronic nephritis (duration) 10 yrs. mos. 10 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Urinalysis, blood chemistry

(Signed) Ruth E. Fairbanks B. P. M. D.

, 19 (Address) Johns Hopkins Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Troy, N. Y.

DATE OF BURIAL 7/24 1929

20 UNDERTAKER W. Cook

ADDRESS 1217 E. Fond St

important. See instructions on back of certificates.

Spec.—1-10-21—M&T—1500 Blks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47821

CERTIFICATE OF DEATH.

44

E 47821

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No.) Franklin Sq. Hosp. ST. 7-55 WARD

2-FULL NAME Margaret A. Will

(a) RESIDENCE NO. 5322 Beaufort Ave. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 49 yrs. 7 mos. 12 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year): Dec. 9-1879

7 AGE — Years: 49 Months: 7 Days: 12

If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Waitress

(b) General nature of industry, business, or establishment in which employed (or employer): Cafeteria

(c) Name of employer: Gas & Electric Co. Baltimore, Md.

9 BIRTHPLACE (city or town) (State or country)

PARENTS

10 NAME OF FATHER: Adolph Will

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Margaret Desch

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Germany

14 Informant: George J. Will (Address) 5322 Beaufort Ave.

15 Filed JUL 22 1929 C. HARRISON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 21 1929.

17 I HEREBY CERTIFY, That I attended deceased from July 1, 1929. to July 21, 1929.

that I last saw her alive on July 21, 1929,

and that death occurred, on the date stated above, at 11:30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Stomach and liver

(duration) yrs. 6 mos ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 15, 1929

Was there an autopsy? no

What test confirmed diagnosis? Operation

(Signed) Arthur Rattenni, M. D.

7/21, 1929 (Address) Franklin Sq. Hosp.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Holy Redeemer Cemetery, DATE OF BURIAL: July 25, 1929.

20 UNDERTAKER: J. William Offutt, Sr. ADDRESS: 3516 Old Frederick Road.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

60-001

E 47822

REGISTERED NO. **E 47822**

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 145 N Luzerne Ave ST. 6-10 WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary Guzinska

(a) RESIDENCE NO. 145 N Luzerne Ave ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If foreign birth? 30 yrs. mos. ds.
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of

6 DATE OF BIRTH (month, day, and year) Aug 6 1857

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
71	11	15	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer) Housewife

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Poland

PARENTS

10 NAME OF FATHER Joseph Zacharski

11 BIRTHPLACE OF FATHER (city or town) (State or country) Poland

12 MAIDEN NAME OF MOTHER Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Poland

14 Informant John Guzinski

(Address) 145 N Luzerne Ave

15 Filed JUL 22 1929 HARRY JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21 1929

17 I HEREBY CERTIFY, That I attended deceased from Feb 23, 1929, to July 21, 1929, that I last saw h alive on July 21, 1929 and that death occurred, on the date stated above, at 8 30 P m.

The CAUSE OF DEATH* was as follows:,

Mitral insufficiency; Chr interstitial nephritis; toxic goitre; hypertension. Generalized anasarca.

(duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary) Bronchopneumonia

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death? ?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clin data

(Signed) Le Schlenger M. D.

, 19 (Address) 304 E Balto St

*State the Disease Causing Death, or in deaths from Violent Causes, state (I) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Rosary Cem

DATE OF BURIAL 27 1929

20 UNDERTAKER Wm M Wilson 42 S Charles

ADDRESS

Important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

George Abrahon Lane

E 47833

HEALTH DEPARTMENT—CITY OF BALTIMORE

90 E 47833

CERTIFICATE OF DEATH

1—PLACE OF DEATH Baltimore City Hospitals REGISTERED NO.

CITY OF BALTIMORE: (No. 9-17 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME George Abrahon Lane

(a) RESIDENCE NO. 1848 N. Spring ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred? yrs. ? mos. ? ds. How long in U. S., if foreign birth? - yrs. - mos. - ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	Colored	Widowed

5a If married, widowed, or divorced BUSBAND of (or) WIFE of: Unknown

6 DATE OF BIRTH (month, day, and year): Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	68?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: None

(b) General nature of industry, business, or establishment in which employed (or employer): —

(c) Name of employer: —

9 BIRTHPLACE (city or town) (State or country): ? Maryland

PARENTS

10 NAME OF FATHER: Levy Lane

11 BIRTHPLACE OF FATHER (city or town) (State or country): ? Maryland

12 MAIDEN NAME OF MOTHER: Rachel ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country): ? Maryland

14 Informant: Records of

(Address) Baltimore City Hospitals

15 Filed JUL 23 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 20, 1929

17 I HEREBY CERTIFY, That I attended deceased from June 29, 1929 to July 20, 1929

that I last saw h... alive on July 20, 1929

and that death occurred, on the date stated above, at 4:30 A. m.

The CAUSE OF DEATH* was as follows:

Myocarditis Chronic Fatal

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) Pneumonia Lobar Terminal

(duration) yrs. 1 mos. ds.

18 Where was disease contracted If not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Clinical Exam.

(Signed) Harvey M. McLean, M. D.

7-23, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mt Auburn Cem	7-23 1929
20 UNDERTAKER Daniel Easton	ADDRESS 913 Penna

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47834

CERTIFICATE OF DEATH

E 47834

1—PLACE OF DEATH

CITY OF BALTIMORE: (No.) 2144 (St.) Annapolis Rd (WARD) Westport

REGISTERED NO. 25-37

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME John G Baumlein

(a) RESIDENCE NO. 2144 (Usual place of abode) Annapolis Rd WARD

Length of residence in city or town where death occurred 65 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

5a If married, widowed, or divorced, HUSBAND of (or) WIFE of Kate Baumlein

6 DATE OF BIRTH (month, day, and year) March 29 1854

7 AGE	Years	Months	Days	If LESS than 1 day, ... hrs. or ... min.
	78	3	22	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Retired

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Germany

PARENTS

10 NAME OF FATHER Veit Baumlein

11 BIRTHPLACE OF FATHER (city or town) (State or country) Germany

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Germany

14 Informant Kate Baumlein (Address) 2144 Annapolis Rd.

15 23 Filed ..., 19 ... Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 21st 1929

17 I HEREBY CERTIFY, That I attended deceased from April 1 , 1927, to July 21 , 1927 that I last saw him alive on July 21 , 1927 and that death occurred, on the date stated above, at 12:15 P. m.

The CAUSE OF DEATH* was as follows:

Chronic interstitial [illegible]

[illegible] (duration) 2 yrs. mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Symptoms

(Signed) [illegible], M. D.

July 22, 1929 (Address) 541 Fulton Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross a a Co. DATE OF BURIAL 7-25 1929

20 UNDERTAKER Bernard C Harle ADDRESS 1000 S Paca St

IMPORTANT. See instructions on back of certificates.

Cor.—12-9-25—A Co.—200 Bks.

E 47835

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH.

90 E 47835

REGISTERED NO.

1-PLACE OF DEATH

City of BALTIMORE: (No. 31st Street nr Greenmount Ave St. 12-20 Ward)

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 1B.)

2-FULL NAME Rev. Thomas Atkinson

(a) RESIDENCE NO. Hopkins Apts St. Ward Resident

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 69 yrs. 3 mos. 19 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed, or Divorced (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): April 1 1860

7 AGE	Years	Months	Days	IF LESS than 1 day.....hrs. or.....min.
	69	3	19	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Clergyman

(b) General nature of industry, business, or establishment in which employed (or employer): Clergy

(c) Name of employer: Self

9 BIRTHPLACE (city or town): Baltimore

(State or country): Maryland

PARENTS

10 NAME OF FATHER: Dr. Robert Atkinson

11 BIRTHPLACE OF FATHER (city or town): ? ?

(State or country): Virginia

12 MAIDEN NAME OF MOTHER: Georgina H. Keerl

13 BIRTHPLACE OF MOTHER (city or town): Baltimore

(State or country): Maryland

14 Informant: Mrs. Thomas M. Nelson

(Address): Tudor Hall Apts.

15 Filed: HAMPSON JONES, M. D.

Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7/20 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest, (inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest, autopsy or inquiry.) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows: Cerebral Hemorrhage 5 days

CONTRIBUTORY (Secondary) (duration) yrs. mos. ds.

(duration) yrs. mos. ds.

(Signed) (Coroner) M. D.

7/21, 1929 (Address) 3572 Roland Ave

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) Whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents.)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Greenmount Cemetery Date of Burial July 23 1929.

20 UNDERTAKER: STEWART & MOWEN COMPANY (WILLIAM F. MOWEN, Manager)

ADDRESS 106 W. NORTH AVE.

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 47836

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47836

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. Mercy Hosp St. 21-28 Ward)

2-FULL NAME Lee Scheff

(a) RESIDENCE NO. 401 Swartz Ave St., ~~Ward~~ Govans Md.

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. 4 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: M

4 Color or Race: C

5 Single, Married, Widowed or Divorced, (write the word): married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Cylora Scheff

6 DATE OF BIRTH (month, day, and year): June 23-1901

7 AGE: Years 29; Months; Days 27; IF LESS than 1 day hrs. or min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Farmer
(b) General nature of industry, business, or establishment in which employed (or employer): Milling Mill
(c) Name of employer

9 BIRTHPLACE (city or town): South
(State or country) Carolina

PARENTS

10 NAME OF FATHER: Wm Scheff

11 BIRTHPLACE OF FATHER (city or town) (State or country): South Carolina

12 MAIDEN NAME OF MOTHER: Not known

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Not known

14 Informant: Florence Shipe
(Address) 401 Schwartz Ave Govans

15 Filed 19 HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 20 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Fracture Base Skull due to stepping into moving auto on July 17 - on York Rd & Palmer Ave - accidental

(Duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Cardiac failure

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? York Rd & Padonia Rd

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? X ray

(Signed) H. H. Faund M. D.

7-22 19 29 (Address) 2934 W Eldon

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Zion - Govans — DATE OF BURIAL: 7/24/1929

20 UNDERTAKER: Geo. H. Holland — ADDRESS: 1631 Druid Hill Ave

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 47837

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47837

CERTIFICATE OF DEATH

100-00

1-PLACE OF DEATH

City of Baltimore: (No.) Provident Hosp. St., 14-20 (Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Florence Davis.

(a) RESIDENCE NO. 1802 McCulloh St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Fem

4 Color or Race: Col

5 Single, Married, Widowed or Divorced (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: no.

6 DATE OF BIRTH (month, day, and year): Jan — 1929

7 AGE: Years | Months: 7 | Days | IF LESS than 1 day ..... hrs. or ..... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: none
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town): Balto
(State or country): md

PARENTS

10 NAME OF FATHER: Leroy Davis

11 BIRTHPLACE OF FATHER (city or town): Md.
(State or country)

12 MAIDEN NAME OF MOTHER: Florence Buckner

13 BIRTHPLACE OF MOTHER (city or town): md
(State or country)

14 Informant: Florence Davis
(Address): 1802 McCulloh

15 Filed ....., 19.... C. HAMPSON JONES, M. D. Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 20th 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an ..... (Inquest, autopsy or inquiry) thereon and from the evidence obtained by said Autopsy & Inquest (Inquest, autopsy or inquiry) find that said deceased came to death on the day stated above.

The CAUSE OF DEATH* was as follows:

Broncho Pneumonia

(duration) ..... yrs. 1 mos. ds.

CONTRIBUTORY (or secondary): none. Hospital Pneumonia

Autopsy (duration) ..... yrs. ..... mos. ..... ds.

18 Where was disease contracted if not at place of death? 1802 McCulloh

Did an operation precede death? no Date of .....

Was there an autopsy? yes

What test confirmed diagnosis? Yes

(Signed) ..... M. D.

....., 19 (Address) Coroner.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Auburn — DATE OF BURIAL: 7/23/1929

UNDERTAKER: Jos. Geo. H. Holland — ADDRESS: 1631 Druid Hill

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 47838

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47838

REGISTERED NO. 4001

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2 Gough St., 23-31 Ward)

2-FULL NAME Chas E. Edwards

(a) RESIDENCE NO. 34 St. Cross St., Ward

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 Color or Race: Colored

5 Single, Married, Widowed or Divorced, (write the word): Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of —

6 DATE OF BIRTH (month, day, and year): Aug 15 1876

7 AGE: Years 52 | Months 11 | Days 5 | IF LESS than 1 day ... hrs. or ... min.

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work: Laborer
(b) General nature of industry, business, or establishment in which employed (or employer):
(c) Name of employer:

9 BIRTHPLACE (city or town): Balto Md
(State or country)

PARENTS

10 NAME OF FATHER: Carter Edwards

11 BIRTHPLACE OF FATHER (city or town): Md
(State or country)

12 MAIDEN NAME OF MOTHER: Mary Evans

13 BIRTHPLACE OF MOTHER (city or town):
(State or country): Va

14 Informant: Martha Rather
(Address) 34 St Cross St

15 Filed ..., 19.. C. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 20 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to his death on the day stated above.
The CAUSE OF DEATH* was as follows:

Apoplexy

(duration) ... yrs. ... mos. 1 ds.

CONTRIBUTORY (Secondary) Exhaustion

(duration) ... yrs. ... mos. 1 ds.

18 Where was disease contracted If not at place of death? —

Did an operation precede death? — Date of —

Was there an autopsy? No

What test confirmed diagnosis? By History

July 20 1929 (Signed) J C Shadel M. D.

(Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Mt. Zion

DATE OF BURIAL: July 19

20 UNDERTAKER: J. L. Bryant Son

ADDRESS: 1017 Druid

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should make CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—1-10-21—M&T—1500 Bks.

E 47839 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47839

CERTIFICATE OF DEATH.

REGISTERED NO. 108

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. Bon Secours Hospital ST. WARD)

2-FULL NAME Eleanora Kirstukas

(a) RESIDENCE No. 2540 W. Pratt ST., WARD

(Usual place of abode)

Length of residence in city or town where death occurred 7 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced. (write the word)
F	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of

6 DATE OF BIRTH (month, day, and year) 1922 ?

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
About 7 ?				

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work No

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) Baltimore Md.
(State or country)

PARENTS

10 NAME OF FATHER Felix Kirstukas

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Lithvania

12 MAIDEN NAME OF MOTHER Sophia Powilaitis

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore Md.

14 Informant F. Kirstukas
(Address) 2540 W Pratt St.

15 Filed 19

C. HAMPSON JONES, Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7/22 1929

17 I HEREBY CERTIFY, That I attended deceased from 7/17/29, 1929, to 7/22, 1929, that I last saw h alive on 7/22, 1929, and that death occurred, on the date stated above, at 11 A.M.

The CAUSE OF DEATH* was as follows:

Abscess of floor of mouth (submaxillary abscess)

(duration) yrs. mos 14 ds.

CONTRIBUTORY (Secondary) Toxemia

(duration) yrs. mos. 14 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? Yes Date of 7/18/29

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) Theo E Stacy Jr M. D.

19 (Address) Bon Secours Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Cross A.A.C. DATE OF BURIAL July 25. 1929

20 UNDERTAKER John Greblauckas ADDRESS 423 S Paca St

CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 47840 HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47840

CERTIFICATE OF DEATH.

1-PLACE OF DEATH

CITY OF BALTIMORE: (No. 2609 W Fairmount Ave. ST. 20-69 WARD)

REGISTERED NO. 44

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Maggie Skinkis

(a) RESIDENCE No. 2609 W Fairmount Ave ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 27 yrs. — mos. ds. How long in U. S., if of foreign birth? 27 yrs. — mos. ds. (If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
F	W	Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Kazimer Skinkis

6 DATE OF BIRTH (month, day, and year) No. 1880

7 AGE 49 Years — Months — Days | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work No. 27

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country) Lithvania

PARENTS

10 NAME OF FATHER Mik Pascrckis

11 BIRTHPLACE OF FATHER (city or town) (State or country) Lithvania

12 MAIDEN NAME OF MOTHER Maggie Kurtinaitis

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Lithvania

14 Informant K. Skinkis

(Address) 2609 W Fairmount Ave.

15 Filed ... 19 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20. 1929.

17 I HEREBY CERTIFY, That I attended deceased from July 1 . 1929 . to July 20 . 1929. that I last saw h alive on July 20. 1929. and that death occurred, on the date stated above, at 12.30 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of liver.

(duration) — yrs. 6 mos — ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. — mos. — ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? no Date of —

Was there an autopsy? no

What test confirmed diagnosis? Clinical Symptoms

(Signed) G. Thackston M. D.

7/24, 19 (Address) 888 N Loudenn St

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Holy Redeemer July | DATE OF BURIAL 24.1929

20 UNDERTAKER John Grebliauckas | ADDRESS 423 S Paca St.

CAUSE OF DEATH in plain terms, so that it may be properly classified. Each statement of CAUSE OF DEATH is very important. See instructions on back of certificates.

Cor.—10-10-29—A Co.—100 Bks.

E 47841

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47841

CERTIFICATE OF DEATH

1-PLACE OF DEATH

City of Baltimore: (No. Hundredth Hosp St. 7-1-29 Ward)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

2-FULL NAME Elenor Roche

(a) RESIDENCE NO. 1009 Denver St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 6 yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F	W	Child

5a If married, widowed, or divorced HUSBAND of (or) WIFE of none

6 DATE OF BIRTH (month, day, and year) Mar-12-1923

7 AGE	Years	Months	Days	IF LESS than 1 day hrs. or min.
	6	4	8	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Child
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer Child

9 BIRTHPLACE (city or town) Balto Md
(State or country)

PARENTS

10 NAME OF FATHER George Roche

11 BIRTHPLACE OF FATHER (city or town) Balto Md
(State or country) Kate Slaughter

12 MAIDEN NAME OF MOTHER Kate Slaughter

13 BIRTHPLACE OF MOTHER (city or town) Balto
(State or country)

14 Informant G. Roche
(Address) 1009 Denver St.

15 Filed 7-31-29 C. HAMPSON JONES, M. D.
Registrar

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-20 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest (Inquest, autopsy or inquiry.) thereon and from the evidence obtained by said Inquest (Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH was as follows: Ruptured Stomach & Intestines due to her running in front of moving auto whose front Robert Jackson ran over her — accidental (duration) yrs. mos. ds.

CONTRIBUTORY (Secondary) Gut Hemorrhage (duration) yrs. mos. ds.

18 Where was disease contracted If not at place of death? in front of 95 Wash Blvd

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) L. Frame, M. D.

7 23 1929 (Address) 2939 W. Eden

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Cedar Hill	July 24. 1929

20 UNDERTAKER John Grebliauckas F G ADDRESS 423 S Paca St

L 231929

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Cor.—10-10-29—A Co.—100 Bks.

E 47642

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47842

CERTIFICATE OF DEATH

REGISTERED NO. .....

(If death occurred in a hospital or institution, give its NAME instead of street and number and fill out No. 18.)

1-PLACE OF DEATH

City of Baltimore: (No. 2112 Moyer St. 6-10 Ward)

2-FULL NAME Margaret Kohler

(a) RESIDENCE NO. 2112 Moyer St., Ward

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 Color or Race	5 Single, Married, Widowed or Divorced, (write the word)
F	W	Single

5a If married, widowed, or divorced
HUSBAND of
(or) WIFE of —

6 DATE OF BIRTH (month, day, and year) Dec 4 1897

7 AGE	Years	Months	Days	IF LESS than 1 day ..... hrs. or ..... min.
31	32	7	19	

8 OCCUPATION OF DECEASED
(a) Trade, profession or particular kind of work Housekeeper
(b) General nature of industry, business, or establishment in which employed (or employer)
(c) Name of employer

9 BIRTHPLACE (city or town)
(State or country) Balto Md

PARENTS

10 NAME OF FATHER Kohler

11 BIRTHPLACE OF FATHER (city or town)
(State or country) Balto Md

12 MAIDEN NAME OF MOTHER unknown

13 BIRTHPLACE OF MOTHER (city or town)
(State or country) Baltimore

14 Informant Theorol Kohler
(Address) 2112 Moyer St

15 Filed ..... 19.....

JUL 23 1929 C. HAMPSON JONES, M. Reg. Dar

Per .....

CORONER'S CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 1929

17 I HEREBY CERTIFY, That I took charge of the remains described above, held an Inquest
(Inquest, autopsy or inquiry.)
thereon and from the evidence obtained by said Inquest
(Inquest, autopsy or inquiry) find that said deceased came to her death on the day stated above.

The CAUSE OF DEATH* was as follows:

(a) Autopsy

(b) Pneumonia (duration 4 days) yrs. 3 mos. ds.

CONTRIBUTORY (Secondary)

..... (duration) ..... yrs. ..... mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? ..... Date of .....

Was there an autopsy? July

What test confirmed diagnosis? .....

(Signed) J. C. Hades, M. D.

, 19 (Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Sacred Heart Lot	July 24 1929
20 UNDERTAKER	ADDRESS
Martin W. Diffenderffer	27 Light

tion should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

Spec.—2-29-28—L. F. S.—500 Bks.

E 47843

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47843

CERTIFICATE OF DEATH

1—PLACE OF DEATH BALTIMORE CITY HOSPITALS REGISTERED NO. 90

CITY OF BALTIMORE: (No. 9-18 ST., WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME James F. Flore

(a) RESIDENCE NO. 1707 Carey ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., If foreign birth? — yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Widowed

5a If married, widowed, or divorced HUSBAND of (or) WIFE of ?

6 DATE OF BIRTH (month, day, and year) ?

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
80 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Flour

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) (State or country) Balto Md.

PARENTS

10 NAME OF FATHER ?

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md.

12 MAIDEN NAME OF MOTHER ?

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md.

14 Informant Records (Address) BALTIMORE CITY HOSPITALS

Filed JUL 23 1929 C. HAMPSON JONES, M. D. By

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) 7-22-29

17 I HEREBY CERTIFY, That I attended deceased from 10-31, 1928, to 7-22, 1929, that I last saw him alive on 7-22, 1929, and that death occurred, on the date stated above, at 2:30 p.m.

The CAUSE OF DEATH* was as follows:

Sudden death resuscitation
Myocarditis cirrosis

(duration) over 5 yrs. mos. ds.

CONTRIBUTORY (Secondary) Arteriosclerosis

(duration) over 5 yrs. mos. ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis? Physical Exam

(Signed) Merwin H. McLean M. D.

7-22, 1929 (Address) BALTIMORE CITY HOSPITALS

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Mount Carmel	July 25 1929
20 UNDERTAKER	ADDRESS
Marshall J. Hyppel	399 S. Eden

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47844

CERTIFICATE OF DEATH

118-001 E 47844

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 1702 William St. ST. 24-35 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Pauline Repelius

(a) RESIDENCE NO. 1702 William St. ST., WARD
(Usual place of abode)

Length of residence in city or town where death occurred 50 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Wm. Repelius Sr.

6 DATE OF BIRTH (month, day, and year): Feb. 13 1846

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	83	5	9	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Housework

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer:

9 BIRTHPLACE (city or town) (State or country): Germany

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: William Repelius Jr.

(Address): 1702 William St.

15 Filed ..... 19..... C. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 22-1929

17 I HEREBY CERTIFY, That I attended deceased from July 19, 1929, to July 22, 1929

that I last saw h alive on July 22, 1929

and that death occurred, on the date stated above, at 3 A.M.

The CAUSE OF DEATH* was as follows:

Strangulated Hernia

CONTRIBUTORY (Secondary) Exhaustion (duration) yrs. mos. 4 ds.

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) L. L. Campbell, M. D.

July 23, 1929 (Address) 1644 Hanover St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Cedar Hill Cemetery

DATE OF BURIAL: 7/24 1929

20 UNDERTAKER: L. Few McCully

ADDRESS: 130 E. Fort

Important. See instructions on back of certificates.

Spec. 2-29-28 L. F. S. 500 Blks.

E 47845

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47845

CERTIFICATE OF DEATH

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. University Hospital ST., 22-42 WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME William Henry Heidhardt

(a) RESIDENCE NO. 3007 Northern Parkway ST.. WARD

(Usual place of abode)

Length of residence in city or town where death occurred 0 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

important. See instructions on back of certificates.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Married

a If married, widowed, or divorced HUSBAND of (or) WIFE of Mary Heidhardt

6 DATE OF BIRTH (month, day, and year) Jan 17, 1887

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or . min.
	42	6	5	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Fireman (City)

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Balto City

9 BIRTHPLACE (city or town) (State or country) Balto, Co (HAMILTON)

PARENTS

10 NAME OF FATHER John Heidhardt

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Co Gardenville Md

12 MAIDEN NAME OF MOTHER Elizabeth Baker

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto, Co (HAMILTON)

14 Informant Mrs. Mary Heidhardt

(Address) 3007 Northern Parkway

15 Filed JUL 23 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 22-1929

17 I HEREBY CERTIFY, That I attended deceased from July 6 . 1929 . to July 22 . 1929 . that I last saw h[illegible] alive on July 22 . 1929 and that death occurred, on the date stated above, at 8:45 A m.

The CAUSE OF DEATH* was as follows:

Nephrolithiasis

(duration) ? yrs. mos. ds.

CONTRIBUTORY (Secondary) ~~Thrombosis~~ ILIAC Thrombosis

(duration) yrs. mos. 2 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? Yes Date of July 19, 1929

Was there an autopsy? No

What test confirmed diagnosis? Clinical

(Signed) Luther E Luke, M. D.

. 19 (Address) University Hospital

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Parkwood Cemetery	July 24 1929
20 UNDERTAKER	ADDRESS
Frederick Loselbo Sons	Fullerton

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

91-002

E 47846

CERTIFICATE OF DEATH

E 47846

1—PLACE OF DEATH

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 16 South Eden ST. 3-5 WARD)

2—FULL NAME Rachel Gerwig

(a) RESIDENCE NO. 16 South Eden ST., WARD
(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 57 yrs. 9 mos. 7 ds. How long in U. S., if foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	White	Widow

6 If married, widowed, or divorced HUSBAND of or WIFE of The Late Lawrence W. Gerwig

6 DATE OF BIRTH (month, day, and year) Oct 13 1871

7 AGE	Years	Months	Days	If LESS than 1 day, hrs. or min.
	57	9	7	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer Self

9 BIRTHPLACE (city or town) (State or country) Baltimore Md

PARENTS

10 NAME OF FATHER John H. Horner

11 BIRTHPLACE OF FATHER (city or town) (State or country) Balto Md

12 MAIDEN NAME OF MOTHER Elizabeth Rodgers

13 BIRTHPLACE OF MOTHER (city or town) (State or country) Balto Md

14 Informant James G. Horner

(Address) 16 South Eden

15 Filed 7-24 1929 HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 20 1929

17 I HEREBY CERTIFY, That I attended deceased from July 10 1929 to July 20 1929

that I last saw h alive on July 19 1929

and that death occurred, on the date stated above, at 9.30 P. m.

The CAUSE OF DEATH* was as follows:

Arterio Sclerosis

(duration) yrs. mos. 10 ds.

CONTRIBUTORY (Secondary) C of L Cancer

(duration) yrs. mos. 1 ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? — Date of

Was there an autopsy?

What tests confirmed diagnosis?

(Signed) Thy E. Glades, M. D.

(Address) 143 N Bway

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
London Park	7/24/1929

20 UNDERTAKER Geo. Weber & Son ADDRESS 2503 Edmondson Ave

Important. See instructions on back of certificates.

Spec.—1-12-23—M&T—500 Blks.

E 47847

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

E 47847

REGISTERED NO.

1-PLACE OF DEATH West Baltimore General

CITY OF BALTIMORE: (No. 16-68 ST. (WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2-FULL NAME Mr. Joseph E. Ritter.

(a) RESIDENCE No. 5138 Frankletown Rd. ST. WARD

(Usual place of abode)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S., if of foreign birth? yrs. mos. ds.

(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Male

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced. (write the word): Married

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Dixie A. Ritter

6 DATE OF BIRTH (month, day, and year): May 26. 1856

7 AGE — Years: 73 — Months: 1 — Days: 26 — If LESS than 1 day, hrs or min

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Laborer

(b) General nature of industry, business, or establishment in which employed (or employer)

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Md.

PARENTS

10 NAME OF FATHER: Unknown

11 BIRTHPLACE OF FATHER (city or town) (State or country): Unknown

12 MAIDEN NAME OF MOTHER: Unknown

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Unknown

14 Informant: Dixie A. Ritter

(Address): 5138 Frankletown Road

Filed JUL 23 1929

HAMILTON JONES, M. D.

Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 22 1929

17

I HEREBY CERTIFY, That I attended deceased from July 22. 1929. to July 22 1929.

that I last saw him alive on July 22, 1929

and that death occurred, on the date stated above, at 11:45 P.M.

The CAUSE OF DEATH* was as follows:

Cerebral Hemorrhage -

a Hemiplegia - Hypertension

(duration) yrs. mos. ds.

CONTRIBUTORY (Secondary): Chronic Nephritis

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? No Date of

Was there an autopsy? No.

What test confirmed diagnosis? Clinical

(Signed) J. Castagna, M. D.

July 23 1929 (Address) West Balt. General

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Good Shepherd = Rockland — DATE OF BURIAL: July 25 1929

20 UNDERTAKER: John T. Denny — ADDRESS: 715 Light

CAUSE OF DEATH. Be specific, stating the primary cause (disease or injury) directly leading to death and any secondary cause (complication) which may have contributed to death. Primary cause must be entered on line (a). Secondary cause on line (b). Duration must be stated in every case. See instructions on back of certificate. Physician is very important.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47848

CERTIFICATE OF DEATH

46

E 47848

1—PLACE OF DEATH

CITY OF BALTIMORE: (No. 615 W. Cake Ave. St.) 7-48 (WARD)

REGISTERED NO.

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Mary E. Killman

(a) RESIDENCE NO. 615 W. Cake Ave.
(Usual place of abode)

Length of residence in city or town where death occurred 42 yrs. mos. ds. How long in U. S., if foreign birth? yrs. mos. ds.

WARD
(If non-resident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX: Female

4 COLOR OR RACE: White

5 Single, Married, Widowed, or Divorced, (write the word): Married

6a If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles L. Killman

6 DATE OF BIRTH (month, day, and year): March 9. 1887

7 AGE — Years: 42 | Months: 4 | Days: 12 | If LESS than 1 day, hrs. or min.

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: At home

(b) General nature of industry, business, or establishment in which employed (or employer):

(c) Name of employer

9 BIRTHPLACE (city or town) (State or country): Baltimore

PARENTS

10 NAME OF FATHER: Paul Poehlitz

11 BIRTHPLACE OF FATHER (city or town) (State or country): Germany

12 MAIDEN NAME OF MOTHER: Mary Rose

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Balto

14 Informant: Mr. Charles L. Killman

(Address) 615 W. Cake Ave

15 Filed JUL 23 1929 JAMES H. JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): July 22-1929

17 I HEREBY CERTIFY, That I attended deceased from Jan 28 to July 22 19 29

that I last saw h[illegible] alive on July 21 19 29

and that death occurred, on the date stated above, at 6 P. m.

The CAUSE OF DEATH* was as follows:

Carcinoma of Uterus

(duration) 1 yrs. 6 mos. ds.

CONTRIBUTORY (Secondary)

(duration) yrs. mos. ds.

18 Where was disease contracted if not at place of death? —

Did an operation precede death? No Date of —

Was there an autopsy? No

What test confirmed diagnosis?

(Signed) S. L. Buckpard M. D.

7/23 19 29 (Address) 520 N. Paca St.

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL: Oak Lawn Cem

DATE OF BURIAL: July 27 19 29

20 UNDERTAKER: John Merrick

ADDRESS: 2008 Allens

Important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

47849

HEALTH DEPARTMENT—CITY OF BALTIMORE

CERTIFICATE OF DEATH

31 E 47849

1—PLACE OF DEATH Baltimore City Hospitals

REGISTERED NO.

CITY OF BALTIMORE: (No. 6-9 ST. WARD)

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

2—FULL NAME Beecher Meekins

(a) RESIDENCE NO. 125 Jones Court ST., WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred ? yrs. ? mos. ? ds. How long in U. S., if foreign birth? — yrs. — mos. — ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Female	Colored	Unknown

5a If married, widowed, or divorced HUSBAND of (or) WIFE of Unknown

6 DATE OF BIRTH (month, day, and year) Unknown

7 AGE	Years	Months	Days	If LESS than 1 day, ...hrs. or ...min.
	50 ?			

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work Housework

(b) General nature of industry, business, or establishment in which employed (or employer) —

(c) Name of employer —

9 BIRTHPLACE (city or town) ?

(State or country) Maryland

PARENTS

10 NAME OF FATHER Charles Diggs

11 BIRTHPLACE OF FATHER (city or town) ?

(State or country) Maryland

12 MAIDEN NAME OF MOTHER Nicey ?

13 BIRTHPLACE OF MOTHER (city or town) ?

(State or country) Maryland

14 Informant Records of

(Address) Baltimore City Hospitals

15 Filed JUL 23 1929, 19 H. HAMPSON JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year) July 18, 1929

17 I HEREBY CERTIFY, That I attended deceased from July 6, 1929 to July 18, 1929, that I last saw her alive on July 18, 1929 and that death occurred, on the date stated above, at 9:30 A.m.

The CAUSE OF DEATH* was as follows:

Pulmonary Tuberculosis, Chronic

over 6?

(duration) ... yrs. 6? mos. ... ds.

CONTRIBUTORY (Secondary) —

(duration) — yrs. ... mos. ... ds.

18 Where was disease contracted if not at place of death? Home

Did an operation precede death? No Date of —

Was there an autopsy? Yes

What test confirmed diagnosis? Clin. Path. Lab. Autopsy

(Signed) Marvin M. McLean, M. D.

7-22, 1929 (Address) Balto. City Hospitals

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL Asbury cemetery — DATE OF BURIAL July 24 1929

20 UNDERTAKER Edward Bryan — ADDRESS 1691 Orleans St

important. See instructions on back of certificates.

Spec.—2-29-28—L. F. S.—500 Bks.

HEALTH DEPARTMENT—CITY OF BALTIMORE

E 47850

CERTIFICATE OF DEATH

E 47850

REGISTERED NO.

1—PLACE OF DEATH

(If death occurred in a hospital or institution, give its NAME instead of street and number.)

CITY OF BALTIMORE: (No. 223 S, Robinson St. ST. 1-2 WARD)

2—FULL NAME Rosario Charles Mandella

(a) RESIDENCE NO. 223 S, Robinson St. ST. WARD

(Usual place of abode) (If non-resident give city or town and State)

Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U. S., If foreign birth? 25 yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 Single, Married, Widowed, or Divorced, (write the word)
Male	White	Single

5a If married, widowed, or divorced HUSBAND of (or) WIFE of: Single

6 DATE OF BIRTH (month, day, and year): Sept, 15, 1863

7 AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
65	10	6.	

8 OCCUPATION OF DECEASED

(a) Trade, profession or particular kind of work: Fruit Merchant

(b) General nature of industry, business, or establishment in which employed (or employer): Fruit

(c) Name of employer: Propritor

9 BIRTHPLACE (city or town) (State or country): Italy

PARENTS

10 NAME OF FATHER: Viagio Mandella

11 BIRTHPLACE OF FATHER (city or town) (State or country): Italy

12 MAIDEN NAME OF MOTHER: Veronica Grassa

13 BIRTHPLACE OF MOTHER (city or town) (State or country): Italy

14 Informant: Michael Mandella

(Address): 223 S, Robinson St

15 Filed JUL 23 1929 H. A. [illegible] JONES, M. D. Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH (month, day, and year): 7-21-29

17 I HEREBY CERTIFY, That I attended deceased from 4-20-20 1929, to 7-21, 1929

that I last saw h. in alive on 7-20-, 1929

and that death occurred, on the date stated above, at 3. a. m.

The CAUSE OF DEATH* was as follows:

acute multiple arthritis.

(duration) yrs. 3 mos. 1 ds.

CONTRIBUTORY (Secondary): acute myocarditis -

(duration) yrs. mos. 7 ds.

18 Where was disease contracted if not at place of death?

Did an operation precede death? no Date of

Was there an autopsy? no

What test confirmed diagnosis? Clinical

(Signed) S. J. Equarco M. D.

7-22, 1929 (Address) Medical arts Bldg-

*State the Disease Causing Death, or in deaths from Violent Causes, state (1) Means and Nature of Injury, and (2) whether Accidental, Suicidal, or Homicidal. (See reverse side for additional space.)

19 PLACE OF BURIAL, CREMATION OR REMOVAL	DATE OF BURIAL
Holy Redeemer	July 24 1929
20 UNDERTAKER: Frank V. Pepitone	ADDRESS: 2818 E, Balto St.

important. See instructions on back of certificates.

CITY HALL
BALTIMORE 2 MARYLAND

DEPARTMENT OF LEGISLATIVE REFERENCE

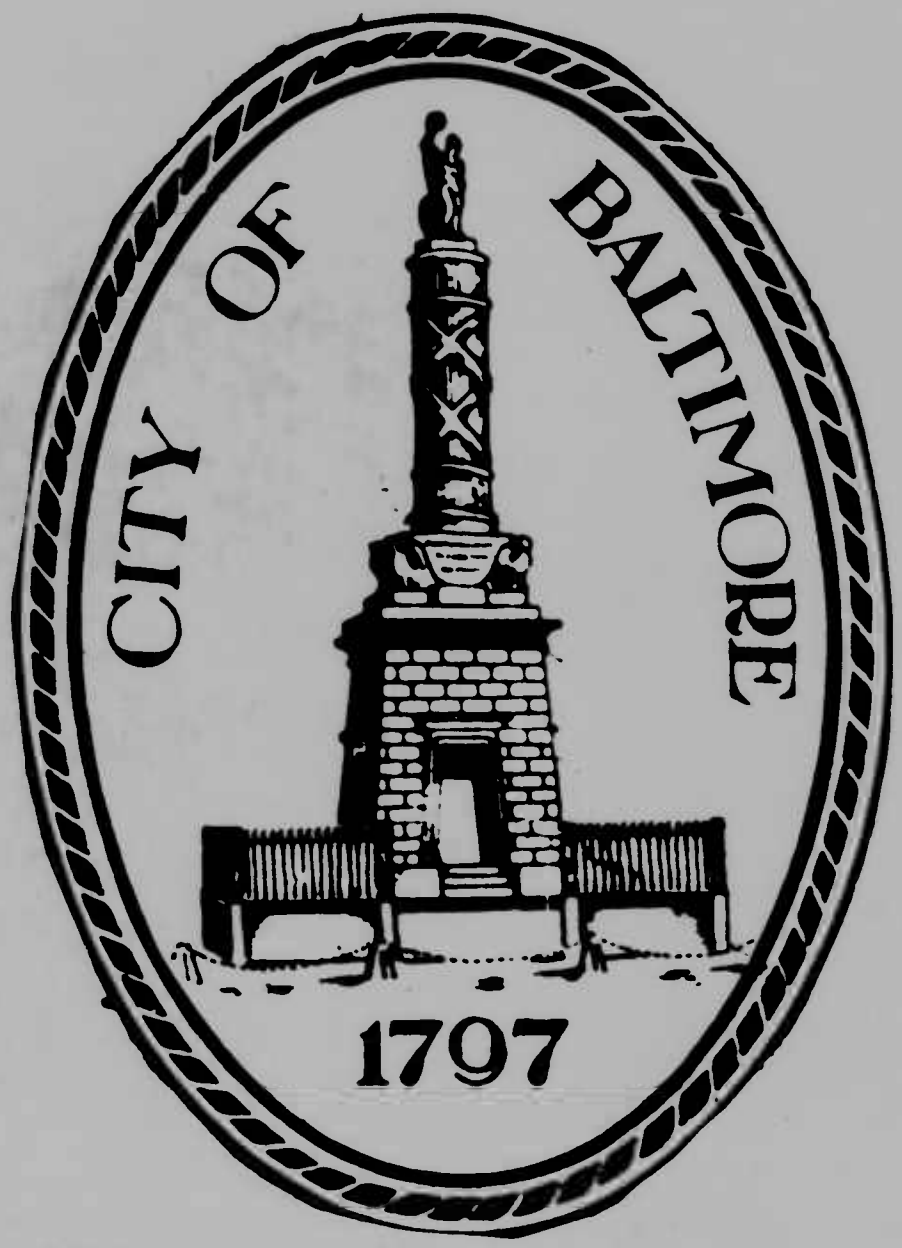
RECORDS MANAGEMENT DIVISION

CERTIFICATION

THIS IS TO CERTIFY THAT ON THIS 27th DAY Apr.
OF 1965 THE MICROPHOTOGRAPHS APPEARING
HEREIN STARTING WITH #E 44316- MARCH 22 1929 AND
ENDING WITH #E 47850- July 23, 1929 ARE AC-
CURATE AND COMPLETE REPRODUCTIONS OF THE
RECORDS OF THE DEPARTMENT OF Health
BUREAU OF Vital Statistics AS DELIVERED
IN THE REGULAR COURSE OF BUSINESS FOR
PHOTOGRAPHING, AND THAT:

TO THE BEST OF MY KNOWLEDGE THE MICROFILM
MEETS THE REQUIREMENTS OF THE NATIONAL BUREAU
OF STANDARDS FOR PERMANENT MICROPHOTOGRAPHIC
COPY.

CAMERA OPERATOR: D McFaul



END OF REEL